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ABSTRACT

The book presents 27 case studies illustrating psychological interventions with behavior problem school children. Studies usually introduce the target population, describe the method of psychological evaluation, report the results of treatment, and discuss the case's implications. Among cases reported are investigations of stimulant medication on hyperactive students, behavioral intervention for a depressed preschooler, a Gestalt approach to counseling an adolescent, the use of cognitive behavior modification, evaluation of hearing impaired students, selective mutism, relaxation training with enuretic students, chronic absenteeism, treatment of encopresis, school phobia, dropouts, and group counseling with secondary school special education students.

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Psychological
Intervention:

Case Studies in School
Psychological Services, Volume 3, 1979

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DEDICATION

This volume is dedicated to PHIL BOWSER and RANDALL RANES for their many faceted contributions to the profession of school psychology in Iowa. Both psychologists have been active in the professional association, have provided inservice training for other psychologists, are noted for their high level of quality service provided to children and have contributed to all three volumes of Psychological Intervention. The dedication of this publication to PHIL BOWSER and RANDALL RANES is in acknowledgement for the sustained effort these psychologists have made in their profession and to the children that the profession serves.

J. G.

FOREWORD

School psychology applies the science of psychology to educational and behavioral problems of preschool and school age children. The goal of this profession is to maximize the human potential of children and assist parents, family members and educators in providing environments which are responsive to the developmental and learning needs of children.

The case studies presented in this publication were contributed by school psychologists working in Iowa during the 1978-79 school year. These studies are provided as examples of the nature and scope of psychological intervention in the schools.

Individualized educational plans (IEP) are often developed for children with special needs since the passage of Public Law 94-142. The following case studies are psychological interventions which have been individualized within an educational setting and have the goal of bringing about behavioral change. By and large, these interventions meet the criteria for an IEP: (1) report on the child's current status prior to the intervention, (2) indicate the projected benefits (goals) of the intervention, (3) specify the intervention to be provided, (4) state the amount of time the child is to be involved in the special services, and (5) determine the method for evaluating the effectiveness of the intervention efforts. The reader will note that these elements are typically included in the case studies in this volume. The IEP is indeed compatible with the practice of school psychology.

Acknowledgements

This publication is made possible with the help of financial resources provided through the Midwest Regional Resource Center and the assistance of the MRRC staff is gratefully appreciated.

Appreciation is expressed to the 26 psychologists who contributed their experiences and expertise reflected in the case studies. Collegial education is not a goal but a reality in Iowa because of the willingness of school psychologists to openly exchange ideas, opinions and concepts concerning the applied aspects of psychology.

Jeff Grimes
Consultant for School Psychological Services
Iowa Department of Public Instruction
May, 1979

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TESTING THE EFFECTS OF STIMULANT MEDICATION
ON A HYPERACTIVE ADOLESCENT MALE

Philip B. Bowser
Grant Wood AEA
Coralville Facility
114 Second Avenue
Coralville, Iowa 52241

Abstract:

Describes the use of teacher observations during medication and placebo treatment conditions to determine behavioral changes of interest to the subject, parents, school staff, and family physician.

TESTING THE EFFECTS OF STIMULANT MEDICATION
ON A HYPERACTIVE ADOLESCENT MALE

Abstract

Describes the use of teacher observations during medication and placebo treatment conditions to determine behavioral changes of interest to the subject, parents, school staff, and family physician.

Introduction.

A decade ago, few physicians prescribed stimulant medications to clam children who appeared to be hyperactive. Parents, teachers, and school psychologists alike were relatively unschooled in the effects of such medication due to a lack of contact. With the increased popularity of the treatment, one now encounters parents who discuss the subtleties of psychotropic medications, school staff

who refer children in order to obtain medication, and children who blame their misbehavior on "forgetting to take my pills." This study was initiated when an adolescent male in the seventh grade used such an excuse for his behavior.

Method.

The student had begun his medication regime several years ago, with the dosage monitored and adjusted as he gained in bulk. His cumulative folder described him as immature, distractible, possessing poor eye-hand coordination and social conformity. Improvement in behavior was reported by both parents and school staff following treatment with Ritalin. He was enrolled in a resource teacher program as a learning disabled student, and received help for reading and mathematics.

Following his claim of innocence by virtue of forgotten pills, a parent conference was called. Both parents and school staff questioned the effect of the medication. At one time, a skipped dose was quickly noticed. Now, it was discovered that many doses had been skipped due to forgetfulness, yet few people noticed. It was agreed to attempt to determine the effects of the medication.

With the additional consent of the family physician, the school staff was approached regarding the project. Using the student as a resource, categories of misbehavior were obtained and clarified to provide more reliable judgement.

Five categories were agreed upon by the school staff and the student in question.

1. EYES. This key word indicated that the eyes of the student were focused away from the instruction, meaning any location other than the student's books, the teacher, or a direction ordered by the teacher. Typically, the Eyes category picked up looking out of the window.

2. NOISES. This key word indicated that the student was making sounds simulating automobile or motorcycle engines, including skidding tire sounds or rocket ship beeps.

3. TALKING. This key word described conversation with another student during a time when such was not authorized by the teacher.

4. OUT OF SEAT. This indicated that the student had reached a full standing position at the side of his chair, when such was not allowed.

5. FORGETTING MATERIALS. Pencils, notebooks, and the like which were required during a particular class but were not visible to the teacher were counted in this area.

Every day, the student carried a piece of paper marked off in a grid of forty squares. The five categories were listed across the top; the eight periods of the day were listed across the left margin. When a teacher observed a given target behavior, they were instructed to use the next available break in the instruction to move to the student's desk. There, the teacher was to quietly tell

the student what error had been made, and observed the student make a tally in the appropriate box. More appropriate behavior was then described to the student. This system served several functions.

First, it enabled data collection without much cost to the staff. Secondly, it provided information to the student regarding the standards of the staff within a reasonable time frame following an error. The self-marking required a student response, hopefully the beginnings of self-monitoring. Also, a teacher-student interaction was required to increase social contacts.

Since the parents had reported backtalking and general misbehavior at home, they asked for a rating system also. Their marking sheets described the time frames corresponding to "just before leaving for school" and "between arriving home and bedtime." To facilitate ease of judgement, they were asked to decide if the time frame went better than usual or worse than usual. These sheets were returned to the school on a weekly basis. Besides satisfying a rating request, the system required the parents to consider the quality of the interactions they were having with the student, rather than simply experience each day.

Placebos were obtained by the family physician from the drug company. The local pharmacist sent enough medication home for one week at a time. Medication was started each Sunday to allow a full day on the medication

before the student was observed at school. Only the pharmacist knew the contents of the bottles, so parents, school staff, and the student were blinded to the treatment condition in effect. The pharmacist was instructed to provide two weeks of Ritalin condition, and two weeks of placebo condition. The exact weeks were left to his choice.

Due to a shipping delay, the school staff had almost one month of practice with the rating system prior to the initiation of the treatment phases. This provides some time to work out the "bugs" in the system. Some problems were encountered initially with the student remembering to carry the sheet, and staff remembering to request that the student mark the sheet. A technique for keeping the ratings from the parents so as not to bias their home ratings was developed. Much of the technical support for the ratings came from the resource teacher, who provided daily contact with the raters.

Results.

As shown in the following tables, the observations supported the hypothesis that the Ritalin was having a positive effect on the student's behavior. The weekly error rankings table showed this most clearly. Over the course of one school week, the student earned two to four times more error scores on the placebo treatment than on the medication treatment.

Table 1
Mean and Median Errors Per Day by Treatment

	$\bar{X}$ Errors Per Day	S.D.	Median Errors Per Day
Baseline	2.11	2.43	2.0
Ritalin	4.0	4.24	3.5
Placebo	7.4	3.13	8.0
Ritalin	1.2	2.16	0.0
Placebo	5.0	5.71	2.0

Table 2
Weekly Error Ranking

1. Placebo 1= 37
2. Placebo 2= 15
3. Ritalin 1= 8
4. Ritalin 2= 6

Table 3
Mean Daily Error Ranking

-
1. Placebo 1= 7.4
 2. Placebo 2= 5.0
 3. Ritalin 1= 4.0
 4. Ritalin 2= 1.2
-

Table 4
Variability Ranking

-
1. Placebo 2= 5.71
 2. Ritalin 1= 4.24
- 3 observations-----
3. Placebo 1= 3.13
 4. Ritalin 2= 2.16
- 5 observations-----
-

Philip B. Bowser

ERRORS PER DAY

100

50

10

5

1

SUCCESSIVE CALENDAR DAYS

11/12/78
day mo. yr.

0 M W F

22/1/79
day mo yr

29/1/79
day mo yr.

3 M W F

5/2/79
day mo yr

13/2/79
day mo yr

6

Baseline

Baseline

Ritalin

Placebo

Ritalin

Placebo

0

10

20

30

40

Discussion.

Certainly, a case study of this type needs careful consideration with regard to the limitations of the experimental design, the accuracy of the data collected, and the decision strategy applied to the data. The public school setting rarely lends itself to tightly controlled studies. Hence, the problem becomes one of obtaining information, which if it is not precise is at least of practical value.

The single-subject ABAB design uses the S as his own control. With many observations obtained over a long period of time, the probability of a single incorrect observation severely altering the results is lowered. There is, however, relatively little control over transient environmental changes which occur at the same time as a treatment. In this study, for example, the parents showed great interest in the student's homework for three of the four weeks. For no particular reason, family checks on the homework just slipped by. During this week, increased misbehavior occurred in school. It can be hypothesized, that part of the motivation for good school behavior is maintained by nightly demonstrations of parental concern.

Accuracy of the observations is another concern. The observations are initiated by nine different observers. Although these individuals have had training over the system, and received reinforcement for their participation through memos to their principal and cookies brought to the staff room,

some evidence appeared to suggest that drift had occurred. One will notice that the trend of the data is towards general improvement across all treatment conditions. Behavior during the second of both placebo and Ritalin treatments showed improvement over the first treatment.

Initially, it would appear that the student's behavior was improving. But a check of daily work showed comments by the teachers to the effect that the student was talking too much during class. Yet for that same class period, no observations were recorded under talking. Anecdotal information such as this suggests the possibility that staff fatigue was setting in. (The project had extended over two months.) The general decline in error scores could also have been explained by a slowly developing failure to record observations. Despite this source of probable error, it is hoped that the magnitude of scores under the two treatment conditions reflects actual behavior, even if the exactness of the scores does not.

An attempt was made to obtain reliability checks. For one period in the afternoon, the resource teacher was team teaching with the regular classroom teacher. Since the resource teacher had helped to design the recording system, and since there were two observers in this period, scores from this time block were judged to be more reliable than any other single block.

If the student's misbehavior were spread evenly throughout the day, one could expect this class period to

account for approximately 12% of the daily errors. If the student's misbehavior increased with fatigue during the day so that the second half of school experienced twice the errors, one would expect the check period to account for approximately 24% of the daily errors. Observing for major deviations from this predicted rate could then be used as a measure of the accuracy of the other seven observation periods.

This system further supported the hypothesis that observer drift had occurred. The percentage of daily errors occurring in the one afternoon class with two observers was 54% during the baseline period. This high rate was expected as staff was learning the system, and the period was additionally broken up by school closings for the weather. The single-classroom percentage dropped to a more acceptable 32-37% during the first two treatment conditions, then rose to the 50-66% level for the final two treatment conditions. Apparently, staff was feeling the effects on an extended program.

Although these cautions may deter the more empirically-minded, the data was of sufficient accuracy to assist the family physician decide on continuance of the medication. At least the decision was based on more information than snap judgements from parents and staff as to the effects. Additionally, the process of observing the student helped the parent to realize that much improvement in behavior had actually occurred over the years. They began to realize that they would "gunnysack" one mistake

from Monday, and use that error to color their perceptions of the entire week. After data collection, it was clear that there were more good days than bad days. This helped the parents to relate to their child as a more normalized teenager, and reduced the effect of the child's identification as the "sick patient."

School staff also reported gaining a more positive perspective on the magnitude of the problem. The data showed a child who averaged 1.2 mistakes per day--hardly a major problem, although verbal reports from earlier in the year described the situation as such.

Follow-up has included relaxation training and concrete rewards for homework completion. The relaxation was added to train the child to consciously produce a lower state of arousal as a response to anxiety over school or peer pressure. Study skills training accompanied the rewards system to increase grades on homework. What began as an alternative to testing has become an increasing involvement.

A BEHAVIORAL INTERVENTION FOR
DEPRESSION IN A PRESCHOOL CHILD

Randall Ranes
Arrowhead Area Education Agency
Storm Lake, Iowa 50588

ABSTRACT:

This intervention was designed to reduce the frequency of a depressive behavior cluster in a four-year-old preschool female. The parents were trained in behavioral techniques and the child was never seen by the writer.

December 20, 1978

A BEHAVIORAL INTERVENTION FOR
DEPRESSION IN A PRESCHOOL CHILD

Abstract

This intervention was designed to reduce the frequency of a depressive behavior cluster in a four-year-old preschool female. The parents were trained in behavioral techniques and the child was never seen by the writer.

Review of Literature

There was little in the behavioral literature reviewed by the writer regarding childhood depression. Lewinsohn and Libet (1972) hypothesized that there is an association between rate of positive reinforcement and the intensity of depression. Therefore, the parents were given instruction in how to reinforce, reinforcement schedules, etc., to cover this and as a part of the intervention for the target behavior. It was assumed by the writer (due to chronological age and problems presented) that the subject had social skill deficits. It was postulated that if the subject was taught certain skills, she would be able to lessen her own "depression" through the reinforcement that would occur from these new social skills.

Method

A. The first contact in the case came from the family physician. The physician stated that the subject's mother had approached him on several occasions expressing concern with her daughter's depression. She also stated they had tried various approaches to the problem and were unsuccessful. The mother described the subject as "very unhappy", and stated that she "gets up crying", "won't join in on games (with the rest of the family)", and that

family members many times would find her in isolation engaging in crying behavior. Secondary problems included withdrawal, enuresis (there was previous control established), and sibling rivalry difficulties. The mother stated that the subject would go into a corner or into her room, hide her head and cry. Also, she described her as very shy, insecure, and lacking in a good self-concept.

B. Problem Behaviors

The psychologist asked the mother to put the subject's symptoms of depression in priority form. She felt that the high frequency of inappropriate crying behavior was the largest concern, withdrawal symptoms were second, and enuresis was third. The focus for the behavioral analysis was put on crying behavior with the intent of moving to additional behaviors later.

1. Baseline Data for Crying Behavior

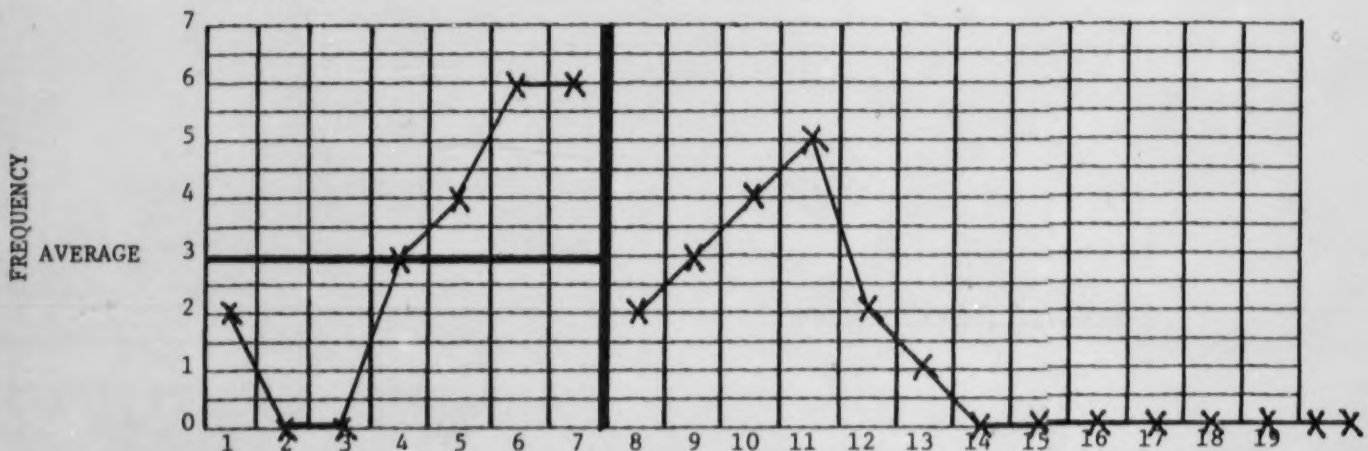
The mother subjectively estimated that inappropriate crying behavior occurred approximately nine times daily. The baseline information was gathered for one week before the intervention was started and showed an average of three per day. The highest number during the baseline observation was six occurrences.

SUMMARY OF BEHAVIORAL OBSERVATION

Behavior 1 Crying Behaviors

BASELINE

INTERVENTION



C. Behavioral Analysis

1. Antecedent Conditions for Crying Behavior

When the mother was asked what types of things occurred right before the behavior, there were some patterns found. The subject usually engaged in crying behavior for manipulation purposes (when she was disappointed or more explicitly, did not gain desired reinforcement) or when her older brother would irritate her in some way.

2. Consequence Condition for Crying Behavior

Next, the mother was asked to explain what usually happened right after the crying behavior. The highest probability consequence was the mother approaching the subject, asking for a reason for the crying behavior, provision of physical reinforcement, and some verbal reinforcement in terms of sympathy-based vocalizations. Occasionally, the subject was punished for inappropriate crying behavior by the mother or father.

3. Environmental Setting Factors

Finally, the mother was asked as to the conditions under which crying behavior appeared less frequent. The mother stated that there was a lower frequency of crying behavior after rest periods and that there were lowered rates after the delivery of an aversive consequence (spanking). The mother stated that the subject was going to preschool and that the preschool teacher had not observed any difficulties with crying behavior. The mother also stated that crying behavior was not observed by the parents of children with whom the subject played. The inappropriate crying behavior appeared to occur primarily in the home setting.

4. Summary of Behavioral Analysis

It appeared to the writer that inappropriate crying behavior was main-

tained by specific contingencies present only in the home environment. This, of course, made a better prognosis. The mother had been unknowingly reinforcing the subject for engaging in inappropriate crying behavior. Also of importance was the lack of certain skills by the subject. The subject needed to develop a wider repertoire of social skills which would enable her to gain reinforcers in a more acceptable manner. She also needed to learn to cope with situations in which a reinforcer was desired but not available.

D. Behavioral Objective

1. Reduce the frequency of inappropriate crying behavior from the average of three times per day to an average of one or less times per day.
2. General Objectives
 - a. Increase the frequency of positive reinforcement given to the subject for appropriate sibling interaction, appropriate use of verbal skills to gain reinforcement, etc.
 - b. Increase the subject's discrimination skills in terms of when it is appropriate to engage in crying behavior.

E. Intervention Design

Both the mother and father received some instruction in the basic principles of behavior. This included discussions on how to reinforce, types of reinforcers, identifying reinforcing, schedules of reinforcement, and how to maximize reinforcement effectiveness. Time was also spent learning how to discriminate between appropriate and inappropriate crying behavior. There was also a bibliotherapy approach taken. They were instructed to read Gerald Patterson's Living with Children and Families; Applications of Social Learning to Family Life.

1. Antecedent Conditions

A behavioral chain was identified for the crying behavior. First, the

subject would hold her head down. Second, she would engage in whining behavior, and third, she would start to cry approximately five seconds after a verbalization came from another person. The parents were instructed to try and break this chain as early as possible. They agreed on a cueing verbalization ("Crying is not going to help your problem") and it was recommended that this be paired with a hand gesture. Both mother and father were present at this stage and emphasis was put on using the same gesture and verbalization. Also, it was suggested that alternative behavior(s) be suggested to the subject. These alternative behaviors would include an appropriate way to get what she wanted and a list of possible verbalizations was provided.

2. Consequence Conditions

The parents were instructed in the technique of ignoring and it was stressed to them that any reinforcement for engaging in inappropriate crying behavior should be withdrawn. They were told of the possibility of a response burst phenomenon. Once the subject stopped crying (all component parts), then the parents could approach her and say something like, "Good, I am glad to see you stopped crying. That is what I wanted you to do. Now let's play a game together" or some similar type of sequence. Reinforcement for dealing with problems in an appropriate way was stressed heavily.

Results

The results of the intervention are demonstrated graphically above. It was assumed that there would be a "response burst" or a slight increase in crying behavior since the change in consequence conditions involved ignoring. Actually, there was not a significant difference from the baseline obtained. After the first week of intervention, crying behavior was occurring approximately .38 times per day. This met the goal of an average of one or less inappropriate crying behaviors per day. The mother was extremely pleased with the results of

the intervention. This was evidenced by verbal behaviors. She also called and thanked the physician for making the referral.

A. Secondary Gains

Though the writer planned to deal with the behaviors presented in priority fashion, there were many secondary gains from the procedure talked about in this paper so far. For example, the mother stated that both withdrawal and enuresis had improved. The writer then asked the mother to monitor enuresis and this did validate a reduction over the original estimate given by the mother. Also, the mother noted a considerable amount of productive social interaction, especially with the family. It should be noted that this could be directly related to the fact that the mother was informally instructed to give the subject cues for appropriate ways (social skill instruction) to obtain the reinforcers she wanted. Enuresis and withdrawal symptoms improved to such an extent that the mother did not want to set up specific plans with the writer for these behaviors. The subject evidently (according to the mother's report) improved her behavior in relationship to playing with a neighbor child, engaging in appropriate behavior to obtain snacks, and increased her social skills used in picking clothes for pre-school in cooperation with her mother.

Discussion

In retrospect, the writer would have definitely chosen to monitor enuresis and withdrawal symptoms (playing in isolation, crying in her room, etc.). It would have definitely been interesting to see how these behaviors were related to crying. They all seemed to be part of what could be called a depressive behavioral cluster, yet the writer did not expect the secondary gains to be as extensive as reported by the mother.

The writer felt that the intervention worked because the controlling variables were identified. If there had not been change within a two-week period, then

it would have become apparent that the interview had not identified the controlling variables. There would have been direct observation by the writer at this time. The writer also feels that the intervention design had much to do with the effectiveness of the intervention. Programming was done in the antecedent environment as well as the consequence environment thus allowing for a way to short circuit the process.

The concept of bibliotherapy was also an important variable. Though the writer did give specific training in the component behaviors necessary for the intervention, the books gave the parents additional information.

GESTALT APPROACH IN COUNSELING
AN ADOLESCENT IN CRISIS

Gary Ross-Reynolds
Northern Trails Area Education Agency
Box M
Clear Lake, Iowa 50401

ABSTRACT: Application of Gestalt therapy is reviewed with emphasis on its utility in crisis intervention. Comparisons between behavioral intervention and Gestalt intervention are presented.

March, 1979

INTRODUCTION

Living organisms display an infinite variety of behaviors which, by definition, are public, observable, and recordable. As such, behavior is amenable to modification and to change. Involvement as a change agent (behavior modifier) in the process can thus be highly reinforcing because results of the agent's efforts are often easily measureable and evident. But humans are more than behaving organisms. Within their physical boundaries, they experience a myriad of sensations, emotions (always evinced somatically), and thoughts of which a given individual may or may not be aware. They are capable of analogue and metaphorical thinking and of constructing more or less serviceable models of their universe (Bandler and Grinder, 1975). They engage in reflection and are aware of themselves as separate from others and from their environments; they conceptualize "myself," and they are conscious (Jaynes, 1976).

While behavior has been the purview of the stimulus-response theorist, the internal processes mentioned above have traditionally been the domain of the phenomenologist. Like the blind men examining the elephant, each group examined a part of the whole and believed that their myopic models coincided with reality. But American psychology is growing and its disparate factions are being bridged and integrated. Through the work of Dollard and Miller psychoanalytic theory embraced behaviorism (Hall and Lindzey, 1970). Cognitive processes and other "intervening variables" were recognized by Hull as integral to a theory of behavior (Hilgard and Bower, 1966). Therapies focusing on behavioral change increasingly are attending to phenomenological processes (Meichenbaum, 1977; Mahoney, 1977; Ellis and Grieger, 1977; Lange & Jakubowski, 1976).

Even Skinner, the guru of operant movement, who in a debate with Rogers, denied the existence of internal states (May, 1962) acknowledged that internal processes must be regarded as part of behavior itself and not simply as mediators of behavior (1964).

The school psychologist is sometimes requested to intervene in situations not amenable to conducting problem identification interviews, collecting baseline data, identifying antecedents and consequences, or establishing reinforcement menus. Such procedures not only require time which may not be available when confronted with yesterday's bleeding wrists today wrapped in tissue, an urgent desire to run away from home or school, or an intense conflict over preference of sex objects, but they also are inappropriate given the immediate demands of the crisis situation. The operant behavior modifier may be inadequate to deal with the intensity of emotion which defines a crisis and is hard pressed to facilitate the tapping of inner resources which will help the individual gain semblance of control. Alternative methods and skills are needed, and Gestalt approaches can facilitate movement beyond the immediate crisis (O'Connell, 1970).

Given the objectives of this paper and the depth and complexity of the subject, it is impossible to present a detailed explanation of Gestalt therapy theory and practice. The reader is referred to the bibliography, especially to the works of Polster and Polster (1974), Zinker (1977), Fagan and Shepherd (1971), and Passons (1975) for further information.

Perls' theory of Gestalt therapy (Perls, 1969; Perls, Hefferline and Goodman, 1951) was born of his study of Freudian theory, his work with Horney and Reich, his contact with the Gestalt psychologists

Wertheimer, Kohler, and Lewin, and his exploration of Zen in Kyoto, Japan (Kogan, 1976). But just as the whole is greater than the sum of its parts, Gestalt therapy theory is more than an amalgam of these and other influences. It is rather, a synthesis of these elements which results in a completely unique conceptual framework having direct implications for therapeutic technique yet allowing latitude for individual therapist styles.

At its base, Gestalt therapy holds several assumptions about people which it shares with other humanistic/existential therapies. Individuals are viewed as a total interrelated system consisting of body, emotions, thoughts, sensations, and perceptions which can only be understood within the context of the individual's environment. As a proactive individual he/she is self-determining, responsible for and capable of making his/her own choices and solving his/her own problems. This process is facilitated once the individual is aware of his/her thoughts, perceptions, sensations, and emotions. By heightening awareness of his/her experiences including remembrances of the past and anticipations of the future which can only be experienced in the present, the individual is capable of self-support. The goal of the therapist is to facilitate awareness and assist the client in discovering his/her own internal support.

The human organism is a kaleidoscope of shifting awarenesses. As your attention is focused on these words you may not be aware of your foot going to sleep, your eyes burning, or the television broadcasting in the background. Once the burning in your eyes increases in intensity, your awareness shifts from these words to the new sensation pressing for attention, then on to still another sensation. Thus, that which stands

out, figure, merges into the background, or ground; ground becomes figure to become ground again.

In a functional person, figure is differentiated clearly, sharply, and distinctly from ground, well-defined like an object in a high-contrast photograph. Such keen awareness of figure usually results in focused behavior by the organism (as the needles in your sleeping foot grow in intensity the pain becomes sharply figural and you probably stop reading to wiggle your toes and ankle) which serves to achieve closure, thus completing the gestalt and allowing another gestalt to become figure (once you awaken your foot closure is achieved and you return your attention to this page). By being sharply aware of both internal and external environments, the functional person is able to use his/her own resources to care for him/herself.

Contrast the process described above to the experiences of the dysfunctional person where the distinction between figure and ground is blurred or diffuse. Instead of standing out, the figure merges and blends with the ground like an unfocused or grainy photograph. Because the person is only vaguely aware of figure, he or she may experience a feeling of nameless discomfort. Like the unfocused figure, behavior, too, is unfocused and aimless, failing to result in closure of the gestalt since the person does not know what the gestalt is that is pressing for closure. The person is thus left feeling helpless, anxious, ineffectual, or frustrated because his/her efforts at satisfying needs prove unsuccessful.

The process and goals of a gestalt session are quite well defined though the specific content (verbal, paraverbal, and nonverbal), therapist's interventions, and therapist-client interaction may vary infinitely. The client and therapist may begin by exploring what the client is aware

of at that moment. Client's awarenesses may, as noted above, often be vague and ill-defined and it is the task of the therapist to be sensitive to where the energy is located and assist the client in focusing his/her energy thereby increasing the client's awareness. Clues to relevant areas are provided by attending to the client's tone and intensity of voice as he/she talks of a given issue and to facial expressions and body movements. The client's awareness may be heightened when the therapist points out inconsistencies between verbal content and nonverbal behavior. By focusing on present ongoing behavior, intellectualization of issues is discouraged; rather the client is encouraged to re-experience past events by reliving them in the present.

METHOD

The client was a 16 year old female of average to above average intelligence with poor academic performance and a history of truancy. She was involved in speech, drama, and art and had a close relationship with some of the younger faculty members. She was brought to the psychologist's office by a teacher during a school vacation period because she was depressed, distraught, and intent upon running away from home. Her teacher had been sympathetic and supportive but felt incompetent to continue to deal with the increasing urgency and intensity of the situation and was very anxious about the possibility of the client's running. The client complained of severe lack of trust between her and her parents. She felt all communication had broken down, and her parents talked with her only to make demands or reprimand her. Her father was reportedly frequently drunk and verbally abusive.

Intervention consisted of one counseling session. The subject was initially intent on talking about injustices at the hands of her parents

and was seeking sympathy from the psychologist because of her plight (she was accustomed to a sympathetic ear from her teacher). Such behavior was not reinforced. As she talked about the terrible ways her parents treated her, the psychologist noted a remarkable absence of accompanying affect; the client seemed detached and matter-of-fact. He guessed that the list had been told many times previously and felt that an additional telling would not serve to heighten the client's awareness of her current conflict. Instead, the client was asked to select a specific issue and re-enact it. She chose an incident involving her father. The client was asked to confront her father directly by telling him her concerns as if he were sitting across from her in an empty chair. After a very few minutes of awkwardness the subject became absorbed in telling her father how she felt about his drinking, discipline, and distance in their relationship. Intense blaming and anger gave way to deep sadness as she continued the dialogue. She was able to own her problem rather than project it and gained new insight into her father's feelings and behavior as well as her own. Her relationship with her father became focused as she discovered fresh ways to approach him. Having learned how she participated in maintaining unsatisfactory (from her point of view) interaction patterns, she discovered alternatives over which she had control and gained some sense of increased potency.

When the dialogue with her father became too difficult for the client to continue, she switched to the pattern with which she had begun--providing history, explanation, and excuses. Her accompanying change of affect was dramatic; the subject immediately became detached and matter-of-fact. The resistance (not labeled as such with the client) was observed, not interpreted, and, while the psychologist

recognized that this behavior allowed her some necessary distance and relief from too painful events, she was encouraged to resume the dialogue.

Additionally, the client was encouraged to explore the polarity of staying versus leaving home. The client's behavior prior to the current session indicated that she was ambivalent about the best course of action to take; she had left home only to return a few hours later to obtain more money. It was upon her return that she contacted her teacher who sought the psychologist's assistance. While the psychologist suspected that she really did not want to run away, providing such an interpretation to the client, no matter how timely or accurate, would not have allowed her to discover this fact for herself.

As the client argued each polarity of the conflict with herself, the psychologist was alert to current, ongoing verbal, paraverbal, and nonverbal behaviors. By sharing his behavioral observations with the client and asking the client to report her internal experiences as she argued each position, the client became much more aware of her feelings toward each position. While she had reviewed the pros and cons of running versus staying many times she was not previously able to move beyond the impasse because she was aware of only one dimension--the intellectual reasons. By ignoring the content and facilitating the client's awareness of accompanying behaviors and feelings, she was provided with powerful new data which she could utilize to make her decision.

DISCUSSION

A crisis situation consists of two major elements: an intensity of emotion and an impasse in which the client feels helpless to move beyond the current conflict toward a resolution of the crisis. At such times

an individual often chooses to escape either by withdrawing emotionally, leaving physically, or, in extreme cases, committing suicide. The role of the psychologist at the point of crisis is to provide support (not salvation) and facilitate the client's rediscovering his/her own support system and power to resolve the crisis. Sympathetic understanding may not facilitate the client's moving beyond the impasse and it may be inimical to the goal of the client's discovering his/her own capabilities to weather the immediate crisis.

By providing the present client with the tools to heighten her awareness of the crisis and develop a well defined, focused figure consisting not only of thoughts but also of feelings and behaviors, she was able to gain a sense of her potency and began to exercise tentative control over her environment.

The desire to run away from home was not the crisis but was the effect of the crisis which was precipitated by her unsatisfactory relationship with her parents, particularly her father. It was with this relationship that the session began. By the client's gaining new insight into the relationship and accepting responsibility for her part in its current unsatisfactory state, as well as discovering new methods to cope with the problem, the crisis became a little more manageable. The question of leaving home thus lost some degree of importance.

Obviously the client's difficulties with her parents were not magically resolved in one session. Nor was one session sufficient to enable the client to discover the full extent of skills available within her to change the interaction pattern long established between her and her parents. It is unfortunate that her parents refused family counseling, stating that "things are much better between us now." The client, too, did not return for further sessions nor did she leave home.

Application of Gestalt principles can facilitate crisis resolution. By first intensifying the conflict the subject can obtain a more focused awareness of the problem leading to greater understanding both intellectually and emotionally. By refusing to offer solutions to the problem, by insisting that the client find the answers within him/ herself, and by providing the support which facilitates this process, the psychologist communicates to the client that he/she possesses the competence and power to arrive at his/her own solutions.

Gestalt intervention shares some characteristics with behavioral intervention. Both approaches concern themselves with current, ongoing behavior. Both approaches can result in marked changes in the client. Both approaches appear deceptively easy to use so techniques of both approaches are often used by individuals lacking sufficient knowledge or respect for the total theoretical system to use them appropriately and wisely. Gestalt intervention may release very powerful and intense feelings in the client. The psychologist must be prepared to positively and competently deal with this emotional intensity. Interventions must be planned at a level of dosage not overwhelming to the client. The client's defenses, manifested as resistances, must be respected and used positively to facilitate change on the part of the client.

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O. Ray Dodson, Ph.D.
Loess Hills Area Education Agency
204 West Seventh
Atlantic, Iowa 50022

THE SUICIDAL STUDENT REVISITED

ABSTRACT:

Over a year ago confrontation was used with a suicidal student. This paper is a presentation of what has transpired since that time.

January, 1979

Introduction

For those of you that didn't know or don't remember that I submitted a paper to this publication last year about the counseling of a suicidal student, let me give you the basic details of the encounter. Mary Smith (not her real name) was being seen by both me and a local psychiatrist because of repeated threats about committing suicide. I was attempting to use a non-directive approach in counseling with her but appeared to be having little success. Simultaneously, but without each other's knowledge, both the psychiatrist and I used confrontation with her. The psychiatrist told her that if she persisted in her suicide threats he would have her committed to the Mental Health Institute at Clarinda. I confronted her with the fact she had such a strong need for recognition and attention from her friends that she was using the best method she knew to get it. However, this was an abuse of the relationship with her friends. As a result of the confrontations, Mary broke off her counseling relationship with both the psychiatrist and myself. It did appear, though, that the threats of suicide were discontinued and her close friends indicated she was happy. However, there was always the possibility that we had merely extinguished the symptoms and nothing was being done about the problem.

Method

Subsequent to the article written in January of 1978, a lot has transpired with Mary. During the second semester counseling sessions were reopened with me (but not the psychiatrist) at Mary's request.

While no rigid counseling schedule has been followed, we have met together a number of times during the remainder of the last school year and this year. The essence of the counseling has been to once again explore the strong need for affection, attention and recognition. There have also been rare occasions when her parents could be included in counseling sessions as well. Mary is now much better equipped to realistically discuss her problems. Also, in order to help her get beyond her feelings of pity for herself, she was assisted in finding part-time employment as an aide in a local sheltered workshop as part of her school day. It is my belief that this job is one of the most significant factors in helping Mary to cope with her problems.

Results

The best way to measure the success of the intervention with Mary is to look at the number of suicidal threats she makes to close friends and the school staff. There have been no instances of threats made during the current school year and the first semester is almost gone. A second way to measure success is through discussions with Mary and her own personal appraisal of the situation. She is quite happy with the way things have turned out. Certainly, she is not a model student in terms of grades, but she has found a way of achieving success and attention through helping the handicapped at the sheltered workshop. Finally, her family is definitely aware of the growth she has made.

Discussion

Once again I must caution anyone working with the suicidal individual that the techniques I used with Mary are not the correct or only way.

O. Ray Dodson, Ph.D.

Each of such situations must be handled in an individual fashion and there should be consultation with colleagues about the matter. I am not sure how successful the confrontation was we used with Mary. That approach could have backfired with the most disastrous results. However, in this case it appeared to make her examine her motivations more realistically, so counseling could really take place. Also, the job placement was a significant factor in her counseling. Finally, let me repeat the fact that the individual who has reservations about counseling the suicidal student should seriously consider using other resource personnel.

TREATMENT OF ENURESIS AND ENCOPRESIS
IN A 5 YEAR OLD GIRL

George G. Bear
Heartland Education Agency
120 S. Hazel
Ames, Iowa 50010

ABSTRACT: The behavioral techniques of modeling, self-correction, and contingent reinforcement were used in the treatment of a 5 year old bright girl who had not used the toilet in the preceding two years.

March 15, 1979

Introduction

The present emphasis in the area of preschool assessment and intervention confronts the school psychologist with unique behavior problems which he often has not been trained to handle. One particular behavior problem found among preschool children is the lack of toileting skills. Because most children toilet independently by the end of the second year, the absence of toileting skills at the age of four or five should be considered a significant problem warranting intervention. (However, infrequent wetting accidents at this age should not be a serious concern.) The school psychologist becomes involved when the child with enuresis (wetting) or encopresis (soiling) is refused entry into a preschool or primary school. Causes for the behavior are sought and remediation is adamantly demanded. At times the wetting or soiling is incorrectly interpreted as being a sure sign of emotional disturbance or a "mental problem". Although many emotionally disabled and mentally disabled children do experience toileting problems, so do children who exhibit no other behavior problems.

There are several possible explanations concerning why a "normal" school-aged child fails to use the toilet. In some cases the problem is medically related and surgery improves the situation. However, surgery often fails to solve the problem and in many cases medical attention actually augments the problem by providing additional reinforcing attention for inappropriate behavior or by producing additional stress to the child. Nevertheless, significant medical problems should always be ruled out before a school psychologist employs intervention techniques.

As noted by O'Leary and Wilson (1975), the approaches employed by psychologists in understanding and treating enuresis and encopresis vary from a strict psychoanalytic approach to a strict behavioral approach. The

psychoanalytic viewpoint maintains that the toileting problem is only a symptom of a more significant underlying emotional conflict that should be the focus of treatment. It is believed that toilet training in such cases would intensify the real problem. The psychoanalytic approach has offered various entertaining interpretations of the underlying conflict, or the root of the problem. However, as expressed by Kauffman (1977) "There is an absence of experimental data underlying the psychoanalytic suggestions that the enuretic (since most enuretics are boys) is trying to cool his fiery penis which has been condemned for its transgressions (or threats thereof) by the superego; that enuresis is a form of direct sexual gratification; that enuresis is symbolic weeping through the bladder; or that the enuretic is urinating on the world in retaliation for the mistreatment that he has received" (p. 233).

On the other hand, behaviorists believe that the child can be directly taught toileting skills without causing emotional harm. Behaviorists perceive the lack of toileting skills as being caused by inadequate habit training or the product of conditioning, and not as being a symptom of emotional conflict. Indeed several behavioral techniques have been found to be effective in the learning and practice of toileting skills (Kauffman, 1977). Behaviorists have effectively used such techniques as over-correction (Ferinden & Van Handel, 1970) time-out procedures (O'Leary & Wilson, 1975), and positive reinforcement in dealing with the enuretic child. Based on research findings the behavioral approach clearly offers the most proven and reliable strategies in the treatment of enuretic and encopretic children.

Initially, the primary purpose of the present study was to demonstrate the effectiveness of several behavioral techniques and the relative ease of which they can be employed in the treatment of both wetting and soiling. Initial optimism prevailed since similar techniques were found to be highly successful

by the experimenter when used earlier with other children. Unfortunately, soon after the study had begun it was quickly discovered that the chosen case was not going to be a simple and routine case of toilet training. Because of the case's complexity and its longer than expected duration, it was not possible to complete the study prior to the deadline set for publication. However, although the terminal goal was not clearly obtained it is believed that the procedures used and the behavior changes which occurred are worthy of reporting to those confronted with similar cases.

Method

Subject. Mary, age 5, was referred to the area education agency by a child care center primarily because of the lack of toileting skills. A comprehensive evaluation found her to be above average in intelligence and average or above in all other areas of development. Her mother described her as being a "very stubborn" and sensitive child, a description which was found to be quite true. Her parents divorced when she was 4 years old. During the time of the study she resided with her mother, 3 year old sister, and 8 year old brother. Her mother noted that toilet training was attempted at the age of 2, at the same time that her younger sister was introduced to the family. During the toilet training Mary did sit on the toilet "several times" but demanded to do so only if her brother was in the same room, which was not allowed. Shortly thereafter she refused to go to the toilet and threw tantrums when told to do so. At the time of the referral Mary had not sat on the toilet during the preceding two years. She had only one bowel movement in the toilet ever. Several treatments had previously been attempted. Three months prior to the referral Mary had surgery for a "urethral stenosis" (constriction of the diameter of the canal that carries urine from the bladder). She visited medical doctors on numerous occasions which involved genito-urinary examinations, enemas, and medication.

Directly prior to the treatment employed in the present study Mary was medically examined and was found to have no physical problems. According to her mother the doctors insinuated that the problem was psychological and not physiological in nature.

Self-correction of her wetting and soiling had been unsuccessfully used for several months by the child care staff prior to the present intervention. With the self-correction procedure Mary willingly changed her own clothes whenever requested. This was the only technique employed at the time of the referral. Also during this time she often received teasing and ridicule from peers for toileting in her pants, which she seemed to ignore. Mary often avoided using the toilet by retaining her urine and stool for lengthy periods of time. The child care staff reported that whenever they asked her to use the toilet she became "disoriented" and usually refused to approach the bathroom.

Procedure. The terminal goal of the intervention was for Mary to be independent in her toileting, as evidenced by the absence of wetting and soiling her pants. The intervention was implemented at the child care center that she attended from 7 a.m. to 5 p.m. Monday through Friday. The study extended over a four month period with 63 days treatment (illness and Christmas vacation interrupted the treatment) and involved six phases: one baseline phase and five intervention phases in which self-correction, modeling, and different procedures of contingent reinforcement were used. The self-correction procedure used prior to intervention, which consisted of having Mary change her clothes after each toileting accident without assistance and with minimal attention from others, was continued throughout all phases of the study. Data were recorded by one of two staff members at the child care center. Weekly consultations were held with the school psychologist. Throughout all phases the staff members were requested to check Mary's pants hourly and to record

daily: (a) the number of times she wet and/or soiled her pants, (b) the number of times she sat on the toilet and used the toilet (i.e. signs of urination or a bowel movement were found in the toilet), and (c) the number of times she sat on the toilet but did not urinate or have a bowel movement.

Phase 1. During Phase 1 baseline data were recorded daily over a 5 day period. The same self-correction procedure as used prior to the study was continued during intervention.

Phase 2. The immediate goal was to have Mary approach the bathroom and sit on the toilet, regardless whether or not she actually used the toilet. Phases 1 and 2 were employed for this purpose. Although it was believed by everyone who worked with Mary that she had the functional skills for toileting and was not using them, it was judged to be necessary to rule out the possibility that she did not have the knowledge of the complete toileting procedure; thus, it was decided to provide a model of toileting skills. Because Mary had a history of strongly reacting to any overture regarding toileting, it was also necessary to make the initial approaches the least stressful. Her 3 year old sister, who was toilet trained and attended the same child care center, was chosen as the model since it was believed that a familiar figure would be less threatening. To further reduce her anxiety Mary was not asked to use the toilet but was only asked by the day care staff to help them by making sure her little sister used the toilet throughout the day. Mary was asked to give her sister a small gum sticker every time she used the toilet. Besides providing a model of toileting skills, the Phase 2 procedure also introduced Mary to the reward system used in the subsequent phases in what was believed to be a less stressful manner than if the reward system had been introduced without the modeling procedure.

Phase 3. Following 7 days of Phase 2 procedures Mary was told that she would be rewarded with one sticker if she sat on the toilet when requested and two stickers if she used the toilet. It was felt by those working with Mary that a request to use the toilet once a day would be less stressful, and more successful, than several daily requests. Thus, Mary was asked only once daily, at 1:00 p.m., to sit on the toilet. To further reduce anxiety she was allowed to be alone while on the toilet, whenever practical. During this phase Mary continued to reward her sister for toileting. Stickers of her choice were immediately given to Mary following her sitting on the toilet for approximately 10 minutes or until she had used the toilet.

Phase 4. The same procedures used in Phase 3 were continued except that Mary no longer rewarded her sister for toileting. The modeling was discontinued since it was believed that it had been effective in introducing Mary to the toileting procedure.

Phase 5. During Phase 5 the reward procedure was used twice daily, at 10:00 a.m. and 1:00 p.m. (the times were chosen based on the convenience of the child care staff). However, Mary could no longer earn a sticker by just sitting on the toilet without using it at 1:00 p.m.; to earn a sticker at 1:00 p.m. she had to use the toilet. At 10:00 a.m. she was given one sticker for only sitting and two stickers for using the toilet. The purpose of this procedure, and the subsequent procedure in Phase 6, was to gradually increase the toileting demands without causing a decrease in toileting behavior.

Phase 6. Two changes were introduced in Phase 6. Mary was now requested to sit on the toilet three times daily, at 10:00 a.m., 1:00 p.m., and 3:00 p.m. She could earn one sticker for only sitting on the toilet at the newly introduced time of 3:00 p.m. and two stickers for using it at that time. To earn a sticker at 1:00 p.m. and 3:00 p.m. it was necessary for her to use the toilet.

The other change involved offering her one choice of several small inexpensive toys upon the collection of 10 stickers. Mary, who understood the concept of number, collected her stickers on a card and receive her toy immediately after earning her tenth sticker. The primary purpose of this procedure was to prevent satiation by introducing a variety of novel rewards.

Results

As illustrated in Figure 1, the intervention procedures were clinically effective in both reducing the number of toileting accidents and in increasing the number of times Mary used the toilet daily. The modeling alone, as used in Phase 2, resulted in a decrease in toileting accidents but did not increase the frequency of using the toilet. This seemingly incompatible result was caused by Mary's retention of her urine and stool. Fortunately, during this phase Mary responded happily to the idea of helping her sister. As illustrated in the top graph of Figure 1, Mary did not use the toilet until the second day of Phase 3 during which time both model and a reward were used. This was the first time she had used the toilet in over two years. Compared to baseline conditions the procedure of using modeling and a reward contingency was effective in improving her toileting skills. Likewise, the procedure accomplished its goal of getting Mary to sit on the toilet. Although at times reluctant, she sat after every request. Improvement continued during Phase 4 conditions when the modeling was withdrawn. Whereas Mary wet and/or soiled her pants on the average of 2.6 times daily during baseline conditions, she averaged only 1.1 accidents during Phase 4, and perhaps more importantly used the toilet 13 of the 20 days in this phase. (It should be noted that the increase in accidents which occurred on days 31, 32, and 33 followed her 1 week absence from the center because of the chickenpox). When requested to use the toilet daily in Phase 5 she did so on 3 of the 7 days. During the remaining 4 days

she used the toilet once daily but only sat, without using it, at the other requested time. Toileting accidents decreased to an average of .29 daily during the 7 days of Phase 5.

The increase in toileting demands to three times in Phase 6, resulted in an average of .59 accidents daily over the 17 day period. Although she never used the toilet 3 times in one day, she was using the toilet more frequently near the end of the study. As with the occurrence of the chickenpox in Phase 4 another unpredictable event occurred in Phase 6 which may have contributed to a temporary decrease in toileting. On days 51, 52, and 53 it was necessary that Mary not use the same bathroom that she had previously been using because of repairs to the room. Consequently, she had to use a different toilet which other children frequently visited. On day 54 her privacy was reintroduced with a subsequent increase in toileting.

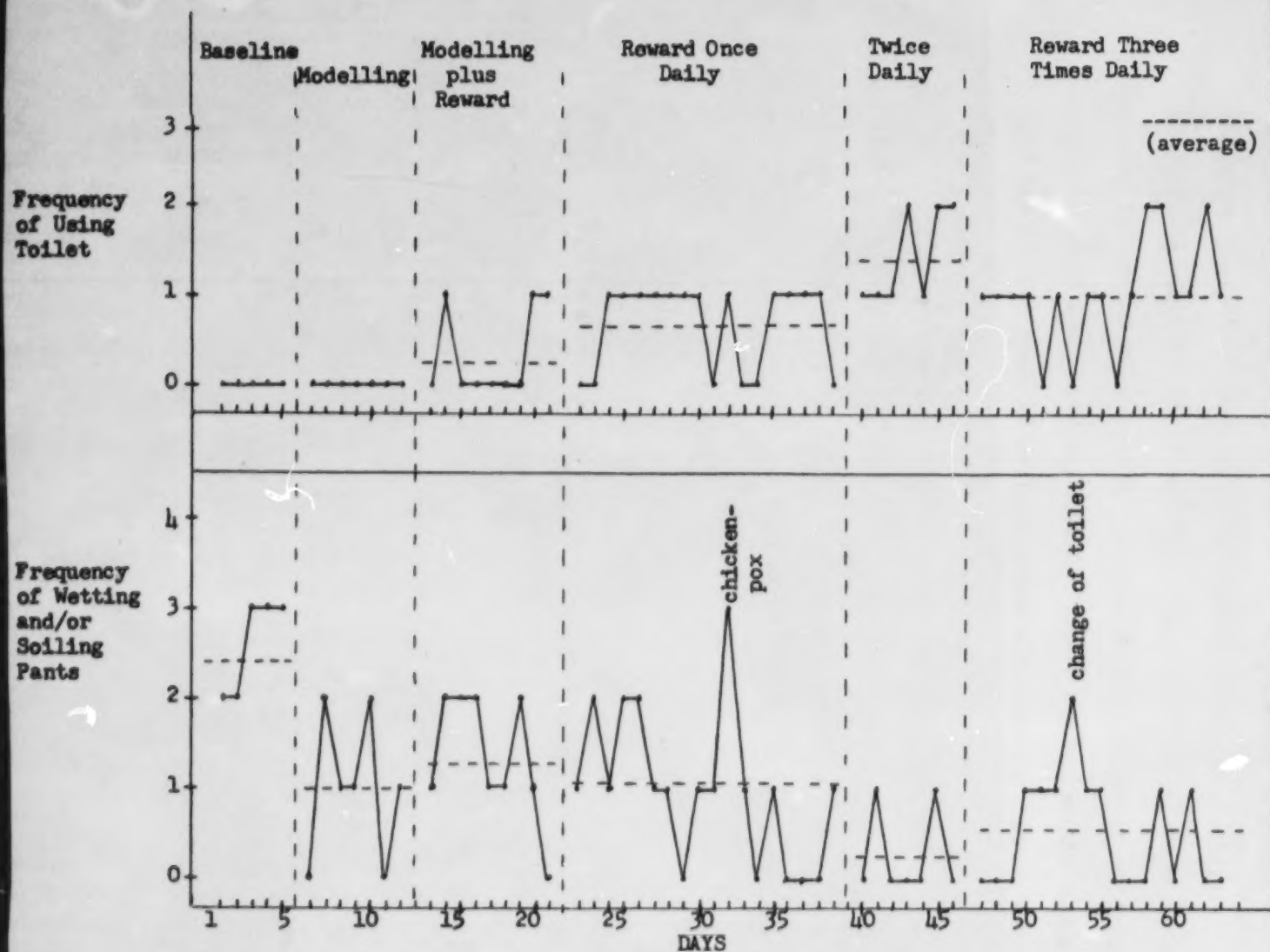


Figure 1. Daily frequency of use of toilet and frequency of wetting and/or soiling pants across intervention procedures.

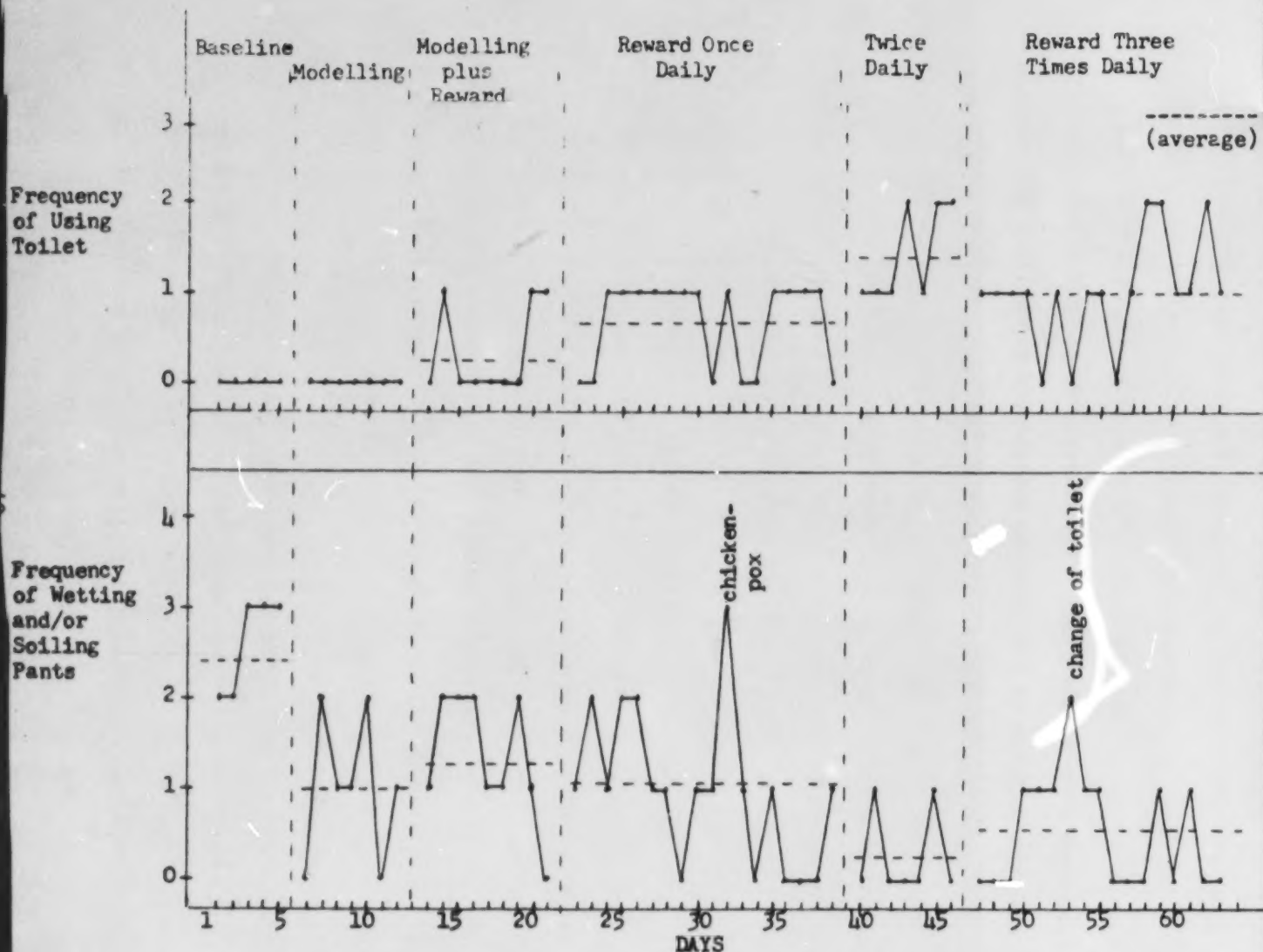


Figure 1. Daily frequency of use of toilet and frequency of wetting and/or soiling pants across intervention procedures.

Discussion

As was noted earlier in the study, several of Mary's behaviors made it necessary to implement different intervention procedures than those used in most cases of toilet training. Throughout the study Mary frequently was "stubborn", as noted by her mother, and sensitive to our approaches regarding toileting. On two occasions she absolutely refused to sit on the toilet, a common occurrence prior to the study. The decrease in toileting found in Phase 6 when the location of the bathroom was changed exemplified her reaction to stress-producing changes in her environment. She never offered more than what was requested by the staff members. Perhaps such behaviors reflect her "personality" or previous conditioning; whatever the cause the behavior did interfere in the experimental procedures and made the study more complex than other toilet training cases. Such was the reason for implementing the procedures gradually. It was felt that more abrupt changes may have caused a return to baseline conditions and/or uncooperative behavior.

One shortcoming of the present study was the failure to establish the reliability of the staff members in recording the data. It is possible that the recorders were not consistent in their monitoring of Mary's toileting. However, it is the experimenter's opinion that such inconsistencies occurred with equal frequency during baseline as during intervention; thus, perhaps lowering the reliability, but not producing a recorder bias, since errors should have been random across phases.

Another possible shortcoming was the chosen design's failure to demonstrate clear experimental control since maturation could have contributed to the improvement in toileting. A withdrawal design was not chosen for ethical reasons. Withdrawal of intervention procedures would have resulted in justified staff resistance and would have served the experimenter's but not the

child's interest. The fact that the mother reported that Mary never used the toilet at home during the study provides somewhat of an across settings multiple baseline comparison, and support for the experimenter's opinion that the procedures employed were the primary cause of improvement. The study does not demonstrate the relative effectiveness of one procedure or phase compared to another. This was not the purpose of the study. Moreover, the chosen design did not allow such comparisons.

Although the procedures were effective in increasing the rate of using the toilet and in decreasing the frequency of wetting and soiling her pants, the terminal goal of establishing independency in toileting had not been reached at the time of publication. Still the child care staff was pleased to see the decrease from an average of 13 accidents weekly to an average of 3 accidents weekly. In order to establish independency in toileting, plans are to gradually phase out the use of adult demands and contingent rewards. In order to facilitate the generalization of toileting behavior to the home, the use of procedures employed at the child care center will be encouraged at home. Moreover, because a mother-child conflict appears to be a contributing factor to Mary's inconsistent behavior, a finding frequently reported by others (Kauffman, 1977, p. 235), individual counseling has been recommended to the mother, not for the purpose of necessarily getting to the "root" of Mary's problem in toileting, but to possibly improve the parent-child relationship and reduce the stressful events which often appeared to be reflected in her toileting behavior.

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THE USE OF COGNITIVE-BEHAVIOR MODIFICATION
AS A
SUPPLEMENT TO OPERANT TECHNIQUES

Bruce F. Jensen
Northern Trails Area Education Agency
Clear Lake, Iowa 50428

ABSTRACT: Presented is the description of the use of cognitive-behavior modification in the form of covert speech and imagery, as a supplement to operant techniques.

March, 1979

Introduction

Meichenbaum (1977) has presented a comprehensive theoretical rationale, description of therapeutic techniques, and review of the research surrounding the increasingly widespread use of "cognitive-behavior modification". The present paper describes the use of this approach as an adjunct to operant techniques. The approach utilizes covert speech and imagery and provides a tool for assisting the student in earning points within a more traditional behavior-modification program.

Method

Mike was a 9-year-old who was first seen for psychological services during the spring semester of his third-grade year. The presenting problems described by his teachers included frequent peer conflicts on the playground and in the classroom, much out-of-seat behavior associated with seeking the attention of the teacher and classmates, and a failure to complete the assigned classroom work. The results of psychological testing indicated that Mike was a youngster of superior intellectual ability who possessed academic skills which surpassed his actual grade placement, although his classroom work seldom demonstrated the acquisition of these skills. Mike was a very verbal subject who spoke about his classroom problems with candor and recognition of his own responsibility for causing many of the problems. During the examination and interview sessions, Mike was somewhat impulsive, attempted to begin working on items before the instructions had been completed, and interrupted when the examiner was talking.

Following classroom observations and several evaluation sessions a staffing was held and it was decided that the initial goal for Mike's behavior would focus upon limiting his out-of-seat behavior. It was thought

that success with this goal would also indirectly improve peer relationships and result in the completion of more assigned work.

After a recording period, during which baseline data was obtained and a "menu" of reinforcers was compiled in consultation with Mike, a behavior modification program was planned and implemented with the goal of reducing the frequency of out-of-seat behavior during instructional and work periods. It was also decided that some additional assistance would be provided to Mike in the form of the provision of some self-control techniques.

The psychologist had met with Mike on several occasions for evaluation sessions and an explanation of the behavior modification program, and a relationship had been developed. At a subsequent meeting Mike was told that controlling a behavior, such as leaving one's desk, can often be made easier by talking to oneself and giving oneself private messages as a reminder to control the behavior. The psychologist and Mike brainstormed a list of such "self-statements" and eventually decided upon one which had been suggested by Mike. The psychologist initially modeled the use of this statement by describing a possible problem situation, weighing several alternative reactions to the situation, deciding to utilize the self-statement to guide behavior, and finally by praising himself for responding in this way.

The next step in the procedure introduced the use of imagery and Mike was asked to close his eyes and imagine that he was seated in the classroom situation. The psychologist then described various classroom situations in detail (this required a familiarity with the classroom and some of Mike's classmates) and cued the appropriate use of the self-statement. Such a procedure was practiced during several sessions and the psychologist provided praise following each imagined use of the statement. Additionally, Mike was taught to congratulate himself for using the technique. The

practice initially involved having Mike pronounce his self-statement and gradually shifted to silent, covert speech. During the final session, Mike was asked to imagine, describe, and respond to possible problem situations which he could anticipate occurring.

Results

The major criterion used to judge the success of the program consisted of the frequency of out-of-seat behavior. Observational data collected by Mike's teacher one month after beginning the program revealed that the frequency of out-of-seat behavior had diminished to approximately one-fifth of its pretreatment level within a structured study situation. She further reported that the quality of his assignments had improved and that he almost always had them completed on time. The quality of Mike's relationships with classmates had not markedly improved and several incidents of fighting on the playground had been reported. However, the teacher felt that her own relationship with Mike had improved as a result of his improved work and the diminished need for her to ask him to be seated. Because Mike was "in trouble" less frequently and had earned points within the behavior modification program, he described himself as being happier at school.

Because several measures were implemented simultaneously, it is difficult to determine their independent effects. It seemed that Mike was an enthusiastic practitioner of the self-statement technique and his parents reported that he had described its use in detail to them.

Discussion

Based upon the present case and others with which the self-statement technique has been used, it has been found to be an important supplement to the successful implementation of behavior modification programs. An important

contribution of the technique seems to result from the child's attribution that he is in control of his classroom behavior and can assume responsibility for his actions by acting in a positive, pre-planned manner. The confidence which results from the success with the technique provides motivation for using it to control other behaviors in new situations. The logical next step in the present case would be to help Mike learn some self-statements to utilize, along with role-playing, which could be directed to the development of new friendship skills.

My own experience with the technique has been limited to youngsters with at least average intellectual ability and verbal skills. The establishment of a relationship, trust of the psychologist, and a willingness on the part of the child to explore his own responsibility for his problems, have seemed to be important prerequisites to beginning such a program.

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EVALUATION OF A SPECIAL POPULATION:
THE HEARING IMPAIRED

Jill Neetz,
and
Jim Spradling, Ed.D.

Area Education Agency 4
Sioux Center, Iowa 51250

Abstract:

The paper reports a case history and group study of 10 hearing impaired children who are integrated in regular classrooms with interpreters for facilitating communication. An individual case and group results are presented.

March, 1979

EVALUATION OF A SPECIAL POPULATION:
THE HEARING IMPAIRED

Introduction

The task was the reevaluation of the hearing impaired children attending the public schools as a part of a special education program for the hearing impaired operated by AEA 4.

A meeting of the parents of the hearing impaired and educational personnel revealed that the parents desired that the children be tested using the interpreters for facilitating communication between the examiner and the child. The special concerns of the parents for their children made it logical that the children should come to the AEA 4 Educational Diagnostic Center for the evaluations. The parents could observe the testing and be immediately involved in the discussions. Video taping could be done to enhance scoring and provide visual information for the teachers on the child's responses and behavior.

The decision was made to have the evaluations in the AEA - EDC, using a team approach. The team would be the local school psychologist, EDC psychologist and the AEA nurse. The nurse would do health screening and make recommendations. The audiologist and the speech and language clinician (who is also the S/L clinician for the hearing impaired) would observe and make recommendations. All children had had audiologicals at the AEA center and all had been evaluated recently by the speech and language clinician. The regular classroom teachers, the resource teacher for the hearing impaired, the principals and the parents were invited to observe the evaluation and participate in the discussions of results and recommendations. (The EDC is equipped with one-way glass between the evaluation rooms and the observation and video taping room).

Description of the population

The subjects for this study consisted of ten severely/profoundly hearing impaired students as defined by a hearing loss of 71 to 91+ decibels. Eight of these students are congenitally hearing impaired. Two students are adopted and background history as to nature of the hearing loss is incomplete. These students range in age from 71 months to 183 months with a mean chronological age of 129.2 months.

These students are considered to be self-contained although they are "housed" in regular classrooms. They work in small groups and an interpreter is provided for communication. Intensive speech and language services are provided on a daily basis and the majority of these children also receive services from a resource teacher for the hearing impaired. There are two exceptions to this, the two students enrolled in the junior high school program spend the majority of the day with a teacher for the hearing impaired for their academic subjects. They are integrated with the regular seventh grade for physical education, art, and music.

Rationale for evaluation of the hearing impaired

A review of some of the literature dealing with the hearing impaired indicated that some special procedures were necessary.

All tests were given by AEA personnel with the help of an interpreter for communication. The interpreter was provided manuals and test directions prior to the evaluation so that certain words and phrases could be changed or adapted to signs understood by the child to be evaluated. The words of the examiner were to be signed as he/she spoke them. In general the interpreter followed a strict interpretation of the examiner's words, but in some instances it was necessary to give the interpreter

latitude as indicated above to change words so that meaningful communication ensued between the child and the examiner.

The battery of instruments for the evaluation would include all or parts of the following:

1. Wechsler Intelligence Scale for Children-Revised (WISC-R). The I.Q. equivalent of the sum of the performance subtest scores would be the reported I.Q. score. Delete the arithmetic, digit span, and mazes subtests. Verbal and Total I.Q. scores would be used for informational and planning purposes.
2. Quick Neurological Screening Test Revised Edition (QNST). The subtest on sound patterns would be changed by using a drum which could be heard by all children instead of oral sound patterns. Tactile rhythmic patterns would be used for the other portion of the test.
3. Woodcock Reading Mastery Tests--the word attack subtest would be deleted and no total reading scores would be reported.
4. Keymath Diagnostic Arithmetic Test. The missing elements subtest would be deleted. The other subtests would be averaged and that score would be plugged in for the missing elements score in order to arrive at a total grade score.
5. Spache Diagnostic Reading Scale. The administration varied somewhat with each child, but generally the child signed and read (silently or aloud, depending on each child's language ability) the appropriate selection and was asked the comprehension questions.
6. Optional instruments:
 - A. Leiter International Performance Scale -- The Leiter was used for two of the four first grade children.
 - B. Bender Visual Motor Gestalt Test (BVMGT).

C. Reading Comprehension subtest of the Peabody Individual Achievement Test (PIAT).

It was the consensus of the staff and those working with the hearing impaired that results would be reported using the standard norms of the instrument. This decision was predicated on the premise that the hearing impaired child was integrated into the regular classroom and that he/she was basically competing with persons of normal hearing for academic achievement. (The hearing impaired had essentially the same assignments and took the same tests that were required of the hearing children). The WISC-R performance subtest scores and I.Q. equivalent would also be reported based on the norms for hearing impaired children developed in a survey by Gallaudet College.

In interpretation of the scores, one must take into account the following circumstances as they apply in each child's case: age of the onset of hearing loss, etiology, degree of loss, stability of loss, type of loss, speech discrimination ability, and amplification devices. The scores are accurate only to the extent that the variables affecting them are understood and controlled. At best the scores are approximations, but as such provide a better than nothing point on which an educational program can be developed.

The general results of the evaluations and a sample case follows.

Results

Anderson and Sisco (1977) have found in their standardization of the Performance Scale of the WISC-R for deaf children that the WISC-R norms for the deaf do not differ greatly from the regular norms. Greatest differences were noted on Picture Arrangement and Coding subtests with the performance of the deaf children being significantly below that of their hearing peers. The following table is a direct reproduction of a portion of their study.

Scaled Score Subtest Pattern For Deaf Standardization Sample

	Scaled Score Mean	S.D.	t*
Picture Completion	9.51	3.23	-5.72**
Picture Arrangement	8.71	3.74	-15.07**
Block Design	9.48	3.37	-6.07**
Object Assembly	10.32	3.24	+3.74**
Coding	8.03	3.32	-23.01**
Mazes	10.03	3.49	-.35NS
I.Q.	95.7	17.55	9.97**

*t calculated for significance of difference between subtest scaled score mean for deaf sample and WISC-R scaled score mean of 10

**significant beyond .01 level

We have attempted to compare the performances of our group of hearing impaired students to the results found by Anderson and Sisco. In looking at our comparison the reader must keep in mind the many statistical problems involved, primarily the small sample size and the wide variability in ages. The t scores were computed using the estimated standard deviation of the mean differences by the following formula:

$$\text{est. } S_{\bar{x}_1 - \bar{x}_2} = \sqrt{\left(\frac{(N_1 - 1)S_1^2 + (N_2 - 1)S_2^2}{N_1 + N_2 - 2} \right) \left(\frac{N_1 + N_2}{N_1 N_2} \right)}$$

$$\text{or } t = \frac{\bar{x}_1 - \bar{x}_2}{\text{est. } S_{\bar{x}_1 - \bar{x}_2}}$$

Following are the results which we obtained:

	Scaled Score Mean	S.D.	t
Picture Completion	7.4	2.63	2.0599*
Picture Arrangement	10.3	4.32	-1.3373
Block Design	8.2	3.33	1.1963
Object Assembly	8.7	2.63	1.5766
Coding	9.8	3.01	-1.6802
I.Q.	92.5	18.58	.032

*t calculated for significance of differences between subtest scaled scores from the Anderson Sisco study and scaled scores on the WISC-R from our sample

In general the results of our sample were consistent with results reported by Anderson and Sisco. Although not significantly different it may be of interest to note that our students scored more closely to the regular WISC-R norms on the Picture Arrangement and Coding subtests than did the students in Anderson and Sisco's sample. One significant difference was obtained in our study on the Picture Completion subtest with our group scoring significantly lower relative to the Anderson and Sisco group.

As a matter of information mean scores for educational instruments are presented below. These scores are perhaps subject to the wide variability in age and ability levels even more so than those of the WISC-R.

Woodcock	Mean instructional grade equivalents
Word Identification	2.7
Word Comprehension	2.6
Passage Comprehension	2.1

Key Math mean grade equivalent 3.2

SAMPLE CASE

Background

Amanda (not her real name) is 13 years 11 months of age. Her parents and two younger siblings complete her natural family. During the school year she lives with a foster family. Her foster parents have two children of their own who are hearing impaired and another foster child who is also hearing impaired.

During pregnancy Amnda's mother had the German measles. Pregnancy was full term with no significant delivery problems noted. Developmental milestones appear to be average or above with the exceptions of speech and hearing. The parents stated that a congenital heart defect was present and was repaired. Amanda also wears corrective lenses.

Tests Administered

Wechsler Intelligence Scale for Children - Revised (WISC-R)

Quick Neurological Screening Test (QNST)

Woodcock Reading Mastery Test Form A

Key Math Diagnostic Arithmetic Test

Peabody Individual Achievement Test - Reading Comprehension

Spache Reading Diagnostic Scle - Comprehension

Results of Testing

QNST --- Twelve of the fifteen subtests were in the normal score range. Two tests were in the suspicious range, (9) Rapidly Reversing Repetitive Hand Movements and (10) Arm and Leg Extension. One test (6) Finger to Nose was in the high range. The overall test score was 25 which puts it at the end of the normal range just below the lowest suspicious score.

Implications: It is not unusual for a few scores to be high in a relatively normal test. The high score on the Finger to Nose test may indicate a lack of development in the proprioceptive and kinesthetic sense. Deficient

performance on these tests might indicate difficulty in school activities that require motor control such as physical education. Results of this test do not indicate a serious deficit.

Woodcock Reading Mastery Tests -- Three subtests were administered: Word Identification, Word Comprehension, and Passage Comprehension. Relative mastery at the 90% level places Amanda's performance at the following grade scores: Word Identification 3.5, Word Comprehension 3.1, and Passage Comprehension 2.8. Easy reading level (96% of mastery) grade scores for the above named subtests are 3.1 - 2.4 - and 2.4 respectively. Failure reading levels for these subtests were 4.1 - 4.2 - and 3.5 respectively.

Implications: Amanda's reading material should be on a third grade level to provide challenge without frustration. The nature of the Passage Comprehension (fill in the blank) seems especially difficult for hearing impaired children and the score may be somewhat depressed below her true ability to comprehend.

Spache Comprehension and Reading Comprehension of the PIAT have very similar results. They place reading comprehension at the 4.5 and 4.7 grade levels respectively.

Implications: The Spache may reveal that Amanda's comprehension is better when questions are related to a story with continuity and substance rather than on isolated and fragmented passages.

Key Math -- Amanda achieved a total test grade equivalent score of 4.3 grade level. Most notable weaknesses were in the areas of Fractions, Word Problems, Money, Measurement, and Time. Relative strengths were shown in the four basic operations (+, -, x, ÷). The items that she did miss involved the calculation of fractions. Amanda also did relatively well on the Mental

Computation subtest which involves performing various operations on a series of numbers and requires the ability to master methods of grouping as well as short term memory.

Implications: Remediation should place emphasis on the practical application skills such as money, measurement, and time concepts in insure a sound mathematic knowledge in skill areas necessary for successful independent daily living. While emphasis should be aimed at these skills, this should in no way preclude instruction in other math areas at her level of functioning.

<u>Test Date WISC-R</u>		Scaled Scores		
<u>Verbal Scale</u>	<u>Scaled Scores</u>	<u>Performance Scale</u>	<u>Scaled Scores</u>	<u>Hearing Impaired Norms</u>
Information	6	Picture Completion	8	8
Similarities	5	Picture Arrangement	11	11
Vocabulary	4	Block Design	7	7
Comprehension	2	Object Assembly	11	10
Total Prorated	21	Coding	10	11
		Total	47	47
		I.Q.	95	95

In discussions of general intellectual ability of the severely hearing impaired when using the WISC-R, the Performance Scale yields the most reliable results.

With a chronological age of 13-11, Amanda achieved a Performance Scale I.Q. of 95±5. This places her present performance in the Average Classification of intellectual functioning and exceeds that of 37% of the children in the standardization group which was roughly representative of the hearing student population of the United States. Her scores were also computed according to WISC-R norms for the hearing impaired with the same I.Q. score resulting. The chances that the range of scores from 90 to 100 reflect her true performance are about 68 out of 100.

Based on Amanda's age and resultant I.Q. her expected level of educational achievement would be approximately at an 8.4 grade placement were she a child of normal hearing. This expectancy will have to be adjusted appropriately in relation to the severity of the hearing impairment, the educational gaps and learning difficulties which necessarily result.

An average score for any child regardless of age on any subtest is considered to be 10. Amanda's individual average score for the Performance Scale subtests was computed and found to be 9.4. Based on this average score there were no significant strengths or weaknesses noted in her performance on these subtests.

Scaled scores were also computed for her performance on verbal subtests and are recorded above. In order for Amanda to obtain average scores on these subtests a fairly sophisticated ability to manipulate language and use verbal concept formation would be necessary. These are of course some of the most difficult skills for the severely hearing impaired child to acquire, needing the most concentrated and continual practice, remediation, and patience.

Recommendations

The book, Sensorimotor Activities, published by Academic Therapy Publications may be useful in working with Amanda on motor control and motor functioning. The activities might be accomplished in physical education class and should help her develop fine control of large and small muscles, i.e., rhythm, smoothness, sequence and symmetry.

Reading material should be on a third grade level. Reading should be taught in the resource room. Amanda should be in competition with her own previous performances. An emphasis should be placed on developing vocabulary.

Setting up tours of various businesses and using the actual situation to name and identify objects would be helpful. Such as two or three days in a local hardware store, furniture store, etc. Some merchants might be willing to cooperate in using their stores as a teaching laboratory.

Reading materials should be challenging but not frustrating. Passage comprehension of a fill in the blank with appropriate word(s) nature has been difficult for each of the hearing impaired children. They should be encouraged to read the entire sentence before trying to supply the correct word(s). Provide stories with continuity and substance rather than fragmented sentences and paragraphs.

Improve practical math skills in the application areas of money, measurement and time.

Vocabulary/Verbal Fluency

Some efforts should be made to increase vocabulary with the understanding that this increase would not be nearly so great or so rapid as with a hearing child. Amanda is able to give good quality definitions for words she knows. Modifications in academic subjects should include emphasis on vocabulary (her understanding of words as well as an increase in her signing vocabulary).

Insure a minimum vocabulary for each subject area where appropriate.

Reinforce knowledge of words she presently uses (words used correctly in context but which she may not necessarily know the meaning of).

Increase fund of general information. This may be accomplished by providing high interest books at Amanda's independent reading level or through discussions of newspaper/magazine articles dealing with current events, or by special project assignments.

Utilize exercises whereby Amanda learns to list several qualities of two or more objects which are alike or similar to increase ability to generalize and see relationships. This may also aid in developing more abstract thinking skills and may extend from concrete objects to abstract ideas.

Comprehension/Judgement/Reasoning

The teacher should present activities in a logical sequence order to facilitate the attainment of goals in an organized and comprehensible manner.

Guide Amanda in understanding cause and effect relationships.

Utilize "What should you do if ...?", "Give me two reasons why ...?", and general "Why?" questions.

Discuss situations which may have several alternatives, why one is better than another or why it isn't.

General

Amanda evidenced some tendency to give up on difficult items. Encourage her to try with the understanding that it is not "bad" to give a wrong answer. Giving incorrect answers is simply a step in the learning process. Trying is just as important as succeeding. Give tasks which may be mildly challenging but at which Amanda has a good chance of succeeding. Praise honest effort as well as successful performance to help develop and maintain a motivation for learning. If the teacher makes a mistake, he/she should admit and discuss this to re-emphasize that everyone makes mistakes. This will provide one of the best models on how to handle frustrations and mistakes.

Amanda appears to have normal intelligence but she should not be expected to function as a hearing person. Individualization of an

educational program with expectations consistent with her hearing impairment is essential to help her reach her potentiality.

Implications of Evaluations

Although not necessarily documented, it often appears that parents of handicapped children as a group are very sensitive to the ordeals that their children must go through to make plans for their future. The team approach -- child, examiners, and parents -- in a setting which provided observation, video-taping and immediate feedback to parents concerns, seemed to develop a greater sense of trust by the parents toward the process of evaluation and toward the persons involved in evaluation.

The relaxed atmosphere and "away-from-school" setting of the EDC appeared to enhance the rapport between examiner and child, thus making possible a more valid evaluation.

The increased dependency on each other of the examiner and the interpreter to provide meaningful and accurate communication to the child proved helpful in carrying out the program changes and the recommendations for curriculum adjustment.

It is readily apparent that changes in standardized procedures of administering tests invalidated score results. Actually this in no way lessened the value of the scores for their practical use in planning for the children. Within the freedom exercised in changing procedures (really no other choice in dealing with special populations) as much consistency as possible was maintained.

A review of our procedures suggests some of the following conclusions. First, all children should have the results of two intelligence tests. Our recommendation would be: 1. the Performance scale of the WISC-R, and

2. the Hiskey-Nebraska or Leiter International Performance Scale. Second, the verbal scale of the WISC-R would not be appropriate for reporting an I.Q. score, but was valuable for purposes of information and comparison with hearing children. It was important in this study because the hearing impaired children were integrated and competing with hearing children.

The passage comprehension of the Woodcock was very difficult for the group and did not seem to adequately reflect each child's ability as compared to actual performance in the classroom. In the future this subtest would be deleted.

As a total project the results of the evaluations were well accepted by parents, teachers and support personnel. Involvement by those named contributed a great deal to the success of the project.

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ELIMINATION OF COMPULSIVE RITUALISTIC BEHAVIOR
IN AN ADOLESCENT GIRL

Ann McClenahan, Ed.D.
Area Education Agency 4
102 South Main
Sioux Center, Iowa 51250

January, 1979

ABSTRACT:

A junior high girl with no previous history of maladaptive behavior began exhibiting compulsive ritualistic behavior, causing both peers and teachers to remark on her "oddness". Diagnosis and treatment involved individual therapy, family therapy (including marital counseling) and consultation with school personnel. Total elimination of the "odd" behavior was attained. Follow-up twelve months later showed no recurrence of symptoms.

ELIMINATION OF COMPULSIVE RITUALISTIC BEHAVIOR
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Abstract:

A junior high girl with no previous history of maladaptive behavior began exhibiting compulsive ritualistic behavior, causing both peers and teachers to remark on her "oddness". Diagnosis and treatment involved individual therapy, family therapy (including marital counseling) and consultation with school personnel. Total elimination of the "odd" behavior was attained. Follow-up twelve months later showed no recurrence of symptoms.

Introduction:

Systems theory suggests an interaction between an individual's deviant behavior and an improperly functioning social organization; the family-oriented counseling approach focuses on social situations rather than on the individual. Sometimes it is advisable to combine treatment modes in order to facilitate behavioral change. The case study submitted herein demonstrates such a combined individual/group therapy mode of treatment.

Method:

Psychological referral of this case was made by the school principal, who reported that teachers were becoming concerned about the child's social isolation and nervousness in the classroom. School personnel had noticed that Joan seemed withdrawn, jittery, and preoccupied much of the time. She seemed to be isolated by the other students.

During my first interview with Joan, she told me she knew she had a problem. She defined this problem as "having to" wash her hands every time she touched her mother, or a teacher, or a classmate. She had found a spot on the corridor wall that was "magic", and she "had to" touch this spot before she washed her hands. She reported that she often washed her hands twenty times in a row and that they were becoming sore from scrubbing them.

Other problems mentioned by Joan included fear of being alone in her room at home, fear of her older sister, and fear of the dog having puppies.

Separate and group interviews were held with Joan's mother, father, and sister to obtain their views of Joan's problem. It soon became evident that family dynamics played a large part in the development of the girl's symptoms. Various forms of symptomology displayed by other family members included alcoholism in the father, wife-beating, heavy drug usage by the sister, and severe marital difficulties between the parents.

Management of this case involved supportive and confrontive counseling for individual family members along with brief marital therapy for both parents as a couple. As each family member gained strength, Joan's symptoms subsided. Joan's mother had been displacing hostility evoked by her husband onto her daughter. As communication improved between mother and father, Joan was no longer scapegoated, and thus had no need to display her ritualistic symptoms as a means of controlling her environment.

Joan's sister, having received implicit parental permission to scapegoat her, now found this permission withdrawn. Although sporadic attempts to continue scapegoating occurred, they became infrequent.

A discussion about the dog revealed concern about Joan's own adolescence and future role as a woman. Her view of women as trapped victims was somewhat realistically based, in view of her mother's role as a victim of physical abuse, and her own scapegoating.

Results:

At the conclusion of eight weeks of treatment, Joan's ritualistic hand washing behavior had completely disappeared. Her fear of being alone in her room vanished. She was still not close to her sister, but was less afraid of her. Concern about her own role as a woman diminished. Both parents reported a feeling of hopefulness about their relationship; Joan's father openly admitted his alcoholism and asked his wife to stand by him as he tried to deal with it.

A six months follow-up found the family situation stabilized, with no recurrence of Joan's symptoms. No evidence of symptom substitution was seen. Follow-up twelve months later showed no recurrence of symptoms.

Discussion:

Some school psychologists might want to refer this type of complex case to a mental health clinic for family counseling. In my case, since my training and experience has included individual, couple, and family counseling, I felt comfortable going ahead with it on a short-term basis. If Joan's presenting symptoms had not ameliorated, the case would have been referred to a mental health clinic.

The role of the school psychologist is seen by some persons as being primarily that of a psychometrician; however, the psychologist who has received supervised counseling training can, at times, offer more comprehensive services to the client and to the school system.

Although Joan's symptoms appeared in the school setting, careful investigation eliminated school personnel and practices as being causal factors or as reinforcing her bizarre responses. Therefore, it was necessary to look at contributing factors present in Joan's primary social group, the family.

No attempt was made to deal with individual symptomatology exhibited by other family members, except as their behavior related to Joan's symptoms.

When faced with a complex case of this nature, each individual school psychologist will need to review carefully his own training and experience to determine case management referral questions.

Annie, Can You Talk?
Selective Mutism: A Case Study

By

I. J. Logan, Ed. S.
School Psychologist
Area Education Agency #12
1520 Morningside Avenue
Sioux City, Iowa 51106

January 1979

Abstract

Annie came to kindergarten with a history of behavior resembling that of an elective mute. She refused to speak to children or teachers although she appeared to enjoy kindergarten and participated in all activities. A combination of social and behavioral interventions are in progress, with some success to date.

Annie came to kindergarten as an elective mute. She refused to speak to children or teachers although she appeared to enjoy kindergarten, and participated in all activities. We could find little information on Elective Mutism in the professional journals, although one article (Patricia Adkins, "Tina Talks", Academic Therapy XI:1:1975; 91-96) helped us realize we were not the first to meet this type of problem. We proceeded on a planned trial/unplanned error basis. Perhaps our unfinished story of limited success to date will help you, should you find an Annie in your system.

Annie surfaced in April, at pre-kindergarten registration. She was an attractive five year old, well dressed, pretty, average size, unremarkable in all respects at first glance. She stayed close by her mother (also pretty, young, well dressed). Annie would not talk to any of us. There was only minimal eye contact with any of the adults involved in the registration activities, and when subjected to direct questions, she simply looked downward, chewing on a thumbnail. She did respond to the non-verbal PPVT, scoring somewhat above the 50th percentile, suggesting at least average mental ability.

We sought out Mrs. Richard (Annie's mother) for interpretation. She reported that early developmental milestones in the child's life had proceeded normally, although Annie had always refused to speak to almost anyone outside the immediate family. The marriage is reported to be healthy, and the family intact. There is one older brother, reportedly favored by the grandmother as the more special of the two children, and Mrs. Richard wondered if perhaps Annie was hurt by this overt rejection, and had resorted to mutism as her way of achieving

"special" status.

Annie had attended nursery school two half days weekly for two years. During that time she had never spoken to the teachers, although there apparently had been some form of communication with one or two children in the class. The mother had tried "everything" - rewards, punishment, deprivation of privileges, bribes, threats, spankings.....it had become a source of contention within the immediate family, with various in-laws giving advice and discussing Annie's "problem" at length, in the child's presence. It was obvious, in this April interview, that Mrs. Richard had some real concerns about Annie's adjustment to kindergarten, but was at a loss how to proceed. She did assure us that Annie's speech at home was normal in every respect, and that with the exception of her self-imposed mutism, she was an average child.

The mother had considered family therapy at one of the local mental health agencies, but rejected it, stating that she did not see a problem at home, and she hoped Annie might "open up" in the fall because she was excited about the prospects of attending school.

Annie established her pattern in the first week of school. She came in quietly, had little eye contact with children or teachers. When feeling threatened or ill at ease, she resorted to the head-down-thumb-nail-in-the-mouth routine. She spoke to no one.

We brought the mother in for conference on the second day, and drew up a plan of action. Our initial goal was to help Annie feel comfortable and totally accepted by all. She was to participate in

all necessary activities with no pressure to talk. The teacher was never to use the words "tell me"; she would say, "let me know..." She was to receive no special attention, the teacher was not to anticipate her needs, and Annie was to find her own way of having her wants met, or do without. The children were not to speak for Annie. We would make no attempt to control the children's reaction to her other than by having the teacher model total acceptance of the child, nor would we work with either the PE or Music teachers, except to apprise them of the situation. (Their time with Annie was limited to, at the most, 40 minutes weekly. For the most part, Annie blended into the class in those activities, and her mutism could probably have gone unnoticed for most of the year.)

For all practical purposes, we had designed this phase well. The children soon gave up their attempts to engage in conversation with Annie, but responded to her in almost direct imitation of the teacher - smiling, playing games with her, commenting on well done work, etc. She was well liked, chosen for games, included in all activities. Initial attempts to respond for Annie, i.e., "Mrs. B____, Annie needs a blue crayon" were ignored by the teacher, and this behavior faded. By the end of September, Annie gave every indication of being at home in the classroom. She was attentive, rarely took her eyes off the teacher during class instruction, played happily with the children, did all assigned work acceptably. On the other hand, however, she never uttered a sound, and although she smiled often she never laughed out loud, and watched with expressionless face during finger plays, group recitation, etc.

(Mrs. Richard was a lunch aide in the building, so we were in sporadic contact with her. We had tried to encourage her to avoid using the mutism as a source of attention for Annie at home, but there was so much emotional investment that this was impossible; since we could control nothing other than the school setting, we discussed that aspect no further. We asked for, and received, a conversational tape Annie had made with her mother. She sang songs, repeated kindergarten rhymes, and at one point told her mother she "wished God would make me talk to Mrs. B ____." Attempts to involve the mother were seemingly ineffective. We scheduled Mrs. Richard's time for Open House when there would be no one in the room besides Annie and Mrs. B _____. Annie showed her mother proudly around the room, but remained mute. She would reportedly talk with her mother in the hall outside the kindergarten room if there was no one in sight, but would not talk with her in the classroom although she loved to have her come in and visit.)

By late October, Annie would sometimes let herself be observed, silently moving her lips during the Flag Salute and rhymes, and was laughing aloud - at this point her only sound.

We had exhausted our supply of ideas. Mrs. B ____ had listened to Annie's tape with the child, commenting on how pleased she was that Annie had learned the rhymes so well. She had sent a tape home in return, which took Annie through class activities, leaving a pause for the child to respond in the appropriate intervals, "for practice." We had tried direct reinforcement (M&M's for all children who named any color found in the room, an extra book from the library for each child who told what they liked to read about); we tried puppet activities,

whispering games, to no avail. Annie was content with her lot....and remained mute.

We moved into Strategy #2, unprofessionally termed "putting the screws to Annie." We began a gradual withdrawal of privileges. To engage in free play during activity time, all children were to state their activity preference - blocks, painting, play house, etc. Annie had been pointing to her choice. At this time she was told that she could choose to participate or not, and if her decision was to participate, she was to state her preference, as did the others. To receive milk all the children were to respond, "thank you." Again, Annie was given the option of choosing whether or not to receive milk. In math, stars were earned for orally identifying the numeral on the page. Through it all, Annie remained mute, and over the period of the next few weeks became glum, less outgoing, occasionally regressing to the earlier downcast eyes-thumb nail chewing routine. This was a low point in time for us as well, and as the frustration and discouragement built, we worried that we were on the wrong track completely.

Early in December, Mrs. Richard, distraught and near tears, asked us to give back Annie's privileges, for the child was sullen and unhappy at home, and didn't want to come to school. She suggested that Mrs. B_____ call the home and carry on a conversation with Annie without identifying herself. (This was the first time we'd been given the information that Annie routinely answered the phone). While agreeing to try it; we talked about Annie's progress in school and (with more enthusiasm that we felt) we reiterated the milestones she had passed; laughing aloud, mouthing words in unison with other children, active

participation in everything that required no speech. We explained that it was possible that Annie felt her comfortable and safe pattern slipping away and was reacting to her fear of change and unknown. For the first time in Annie's life, we felt, we had a consistent and stable environment outside the home in which to reinforce behaviors and apply consequences. We stressed that, if we gave up at this point, we had no further control, and that the first grade teacher would be starting from a minus base, rather than at point zero, in an attempt to break through next year. While academics were not yet much of a consideration, we also emphasized that the reading program required responses.

We reiterated our operational theory; we were attempting to help Annie see that it was she who was choosing to participate or to remain uninvolved, that our requirements for participation were within her ability and were minimal; (the name of the activity desired for free play, a "thank you" for milk, a numeral identified by name for the math star). We also pointed out that while her at-home behavior was apparently normal, she was presenting a severely deviant side in public, and to allow her to return to the level at which she could be comfortably deviant we felt was both inappropriate and potentially dangerous from a long-term psychological outlook. The discussion was emotional and intense, and in the end we received grudging permission to continue.

The following Monday, during the session in which the children chose their activities Annie talked! One word, clearly spoken - "blocks." With all the self-possession she could muster, Mrs. B_____ said, "Thank you, Annie" and called on the next child. For the first time in six

weeks Annie rejoined the group in free play time. The children were excited and there were whispers of "Annie talked!", but with Mrs. B____'s casual acceptance, the children followed suit.

Tuesday brought a tense 20-30 second pause while Mrs. B____ waited for Annie's response during activity-choice time. We were afraid we'd lose her if we pushed, afraid if we didn't push. Finally, with direct eye contact and a staredown from teacher to pupil, Annie murmured her choice in a very small voice. Her response, the rest of the week, was less of a struggle. She was allowed to receive milk (her response was to mouth the words, "thank you"); she remained mute during math and received no stars.

We were concerned about a possible regression occurring during Christmas vacation. Mrs. B____ sent home another tape, giving Annie a preview of the Getting-Ready-to-Read activities, which require oral responses. The tape contained appropriate pauses where Annie could practice. We urged the mother to invite to the home, the little girl from the classroom who seemed to be Annie's "best friend" with planned activities for short periods of time - making cookies, popcorn, or fudge, including the friend on a trip to the library or the Dairy Queen. It was our hope that if she would talk with the child in the home there would be carry-over in the classroom. Mrs. B____ visited the home once during vacation. Annie responded to the doorbell, brought her mother to the door, but did not talk with her teacher.

Now, in early March, Annie is orally participating (but very hesitantly) in all necessary aspects of the school program. She is not a strong student, and it is sometimes difficult during a reading or

math class to determine whether the hesitance is based on emotionality or due to lack of knowledge. On two separate occasions, Mrs. B _____ prompted Annie inadvertently using the words, "Annie, say _____." Annie looked at her directly, and shook her head. When Mrs. B _____ tried again, saying, "Annie, call it _____", the child responded appropriately. She has moved from one word responses to whole sentences, and last week for the first time raised her hand to volunteer a comment during opening exercises. To date, this oral activity is limited to academic demands; she does not engage in conversation with children or staff, with her mother when within earshot of others, or with Mrs. B _____ outside of the classroom.

Annie evidences a great deal of apparently easy comradeship with several other children. She is chosen for games, they rush to obtain seats by her, they walk about with arms intertwined, and there is much eye contact and giggling between them. We have been unable to instigate any oral communication. Mrs. Richard is having no success in inviting other children to play with Annie at home. She reports that Annie says, "You invited them. You play with them." Because Annie is not demanding of her mother's time and entertains herself at home to a large degree Mrs. Richard does not really perceive the mutism as a problem of the same magnitude as we do. Mrs. Richard is reluctant to push the issue, to create a problem for herself where one does not now exist.

We don't know if we are dealing with deep psychological trauma, or simply inappropriate behavior which has been mistakenly reinforced and strengthened by a great deal of social attention. Mrs. Richard

reported that Annie has asked if she (Annie) has a "funny voice" or if she looks "funny" when she talks. The mother and Annie have conversed in front of a mirror and we have urged to use a tape recorder at home more frequently.

DISCUSSION

Elective mutism occasionally seen in young children who use it as a weapon against significant others. In Annie's case, the behavior may also be a learned pattern which she is now somehow afraid to break. Our concern is that the longer she maintains this self-imposed silence, the more difficult it will be for her to develop appropriate patterns of verbal interaction with others.

While our intervention has shown some positive results relative to the academic work, we have not yet been able to generalize this behavior to social, or out-of-class settings. I strongly believe that our success to date is largely due to Annie's teacher, who was able to accept her own frustrations over a period of long and arduous weeks, and provide a consistent environment for the child.

It has been more difficult dealing with the home than we anticipated. Annie's father has never become involved, and we have been unable to identify the reinforcer which is maintaining the behavior at home.

Because Annie is not a strong student academically, our task is more difficult. We cannot allow her to become discouraged with the learning process nor can we put ourselves in the position where we are not actively attempting to elicit that which she is capable of achieving.

We realize that all teachers deal with youngsters with problems in different ways; to the degree that we are able, we will see that Annie is placed next year with a staff member who is most able to deal with the child objectively. With a less accepting teacher as a model, we fear that the children might soon consider Annie "different", and react accordingly.

CONSULTATION AND COUNSELING: A COMBINED APPROACH

Kim Hoogeveen
Lakeland Area Education Agency
Spirit Lake High School
Spirit Lake, Iowa 51360

Abstract

An intervention approach combining behavioral consultation and direct counseling proved successful in reducing a fourth grade boy's inappropriate classroom verbalizations while increasing his confidence in his ability to control his own behavior.

February, 1979

INTRODUCTION

Bergan (1977) has proposed a behavioral consultation model for school psychologists that includes a three-step teacher interview process. During the Problem Identification Interview the behavior of concern is specified and defined, and a procedure for recording a baseline rate is determined. Within the Problem Analysis Interview the results of the observation recording are reviewed and an intervention plan is jointly designed by the teacher and psychologist. After the intervention has been implemented the Problem Evaluation Interview serves to assess its success or failure and identify necessary modifications. Although not necessarily identical, similar procedures are presently being used by many psychologists as the popularity of "consultation" continues to grow (Kupisch, 1978).

A commonly heard objection to behavioral interventions is that the focus is on the environment as opposed to the child. The exclusive goal is to modify the immediate behavior of concern. Counselors such as Glasser (1965) and Pine (1969) have expressed strong arguments that the counselor should be directly engaged in helping the child to develop feelings of self awareness and an understanding of individual responsibility.

The case reported below involves a nine year old 4th grade boy (Bobby) that was referred for psychological services by his parents and classroom teacher. The referral form indicated the primary concern to be with his disruptive verbalizations in the classroom. An approach combining behavioral consultation and individual counseling was implemented.

METHOD

During the initial conference (Problem Identification Interview) with the classroom teacher Bobby was described as being "unable" to restrain himself from speaking out inappropriately and extremely disruptive in the classroom. The behavior was particularly noticeable during group discussions. The teacher reported that several interventions had been tried prior to the psychological referral: stopping class to admonish Bobby, ignoring the behavior, proximity and physical contact and heart-to-heart conversations. None appeared to have appreciably reduced the verbalizations.

At the conclusion of the conference it was agreed that Bobby's behavior would be observed and recorded for three days. The behavior to be recorded was defined as being "unsanctioned verbalizations during class period that were loud enough to be heard by the teacher and other students". During this baseline period the teacher agreed to ignore Bobby's speaking out other than to record and when possible, note what classroom activity was in progress at the time of the verbalization. A copy of the definition and a jointly designed observation form was left with the teacher.

At the second conference (Problem Analysis Interview) four days later the observation chart was reviewed. Bobby's inappropriate verbalizations had ranged from 20 to 30 times per day. The teacher had noted that most of Bobby's speaking out behaviors occurred during class discussion periods. He rarely interrupted the teacher, but frequently added his own comments to those of other students.

A response-cost intervention paradigm was then designed whereby Bobby was to be given five (5) red tokens at the start of each school day and five

more red tokens at the beginning of each afternoon. Bobby would have to return one token to the teacher each time he inappropriately verbalized during the class period. Each remaining token could be cashed in for three minutes of free time in the library at the end of the school day. If he lost all five red tokens he would then receive one (1) blue token each time he spoke out. For each blue token received Bobby was to stay after school for two minutes. Parental consent for the intervention was sought and received.

A counseling session was held with Bobby prior to implementing the intervention program. Bobby expressed an awareness of his inappropriate classroom behavior. He stated that he often caused problems for his teacher by speaking out and that many of the other students were tired of hearing him. Early in the session Bobby stated that "I just can't stop myself". Much of the session was spent with the counselor expressing his confidence in Bobby's ability to control his own behavior and attempting to elicit from Bobby a commitment to reduce his speaking out. At the conclusion of the session Bobby did express his intention to reduce his classroom verbalizations.

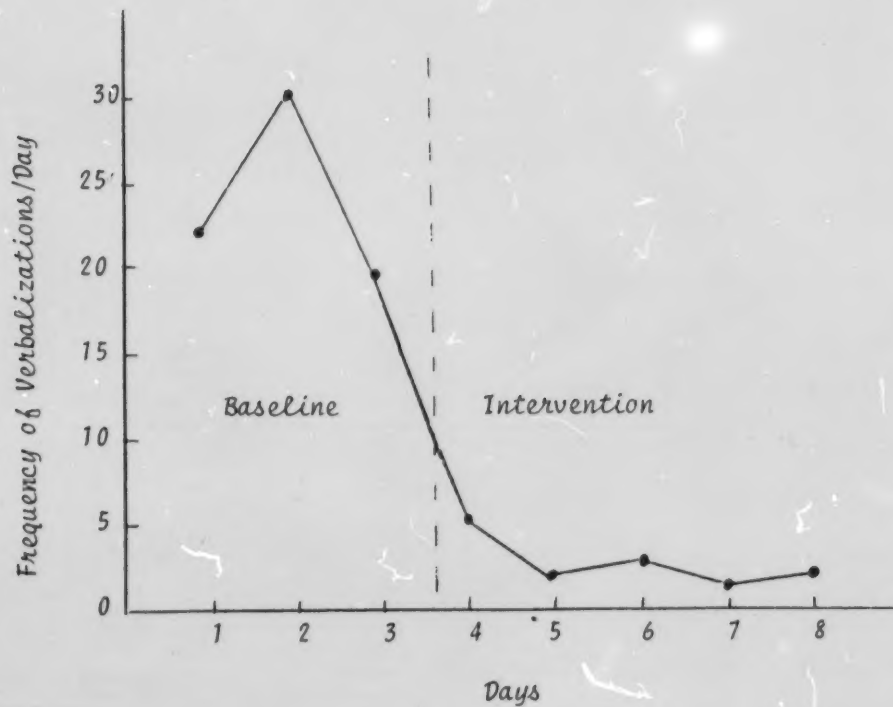
The following morning the classroom teacher praised Bobby for his intention to reduce his speaking out and explained that she wanted to reward him if his efforts proved successful. She then explained the intervention program and gave Bobby his five red tokens.

RESULTS

The intervention proved to be immediately successful in reducing Bobby's verbalizations (see Figure I). After the second day of the program Bobby told his teacher that he needed only three tokens per half day. His teacher praised

him for his improvement and willingness to take responsibility and readily agreed to reduce the number of red tokens. To reward his initiative she increased their value from three to five minutes of free library time. At the end of the fifth day Bobby and his classroom teacher agreed that he had been sufficiently rewarded and that the program could be discontinued.

FIGURE I



No formal recording has been done subsequent to the program's discontinuation. The teacher has reported (Problem Evaluation Interview) Bobby's frequency of speaking out to have remained low, although she did note some increase during the week prior to Christmas vacation. A second counseling session was held at that time. Bobby was aware that he had regressed and attributed it to his excitement about Christmas. He expressed assurance that he would return to a lower frequency after Christmas break and his teacher reports he has been successful in doing so.

DISCUSSION

This case demonstrates the effectiveness of relatively simple behavioral interventions for reducing disruptive classroom behaviors. The unusual procedural aspect is the inclusion of a counseling session prior to the implementation of a behavioral program. Although behavioral improvement would undoubtedly occur without the counseling step, the child is likely to view his improvement as resulting from external forces and contingencies instead of his own commitment and abilities. This additional step offers an opportunity to combine counseling approaches, such as reality therapy (Glasser, 1965), with behavior modification techniques. The emphasis during counseling may be placed on the importance of taking responsibility for one's actions. The counselor can provide support and encouragement for such attitudes and hopefully elicit a positive commitment from the child. The behavioral program can then serve to help the child experience success. With this procedure the goal becomes not only to reduce inappropriate behavior, but in doing so to build the child's confidence and self-reliance.

Bobby's increased confidence was demonstrated when he suggested reducing the number of red tokens he was to receive and verbally expressed during the second counseling session when he gave assurance his behavior would improve after Christmas break. This attitudinal change can be directly attributed to his successful reduction of classroom verbalizations. Hopefully, this confidence and willingness to take responsibility for his own behavior will generalize to other situations and behaviors.

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RELAXATION TRAINING AS AN INTERVENTION FOR ENURESIS:
A CASE STUDY

Paul J. Kudrav
Northern Trails Area Education Agency
226 North Best Street
Forest City, Iowa 50436

ABSTRACT:

This case study deals with a youngster that was 10 years old when he was referred as an enuretic. It was hypothesized that stress was inducing this youngster's bedwetting; therefore, relaxation training was utilized as an intervention strategy. These relaxation procedures were successful.

March 6, 1979

RELAXATION TRAINING AS AN INTERVENTION FOR ENURESIS:
A CASE STUDY

ABSTRACT

This case study deals with a youngster that was 10 years old when he was referred as an enuretic. It was hypothesized that stress was inducing this youngster's bedwetting; therefore, relaxation training was utilized as an intervention strategy. These relaxation procedures were successful.

INTRODUCTION

Enuresis has traditionally been viewed from a medical model and treated through the use of medications. Imipramine or Tofranil are the most frequently cited medications used with chronic bedwetters. These antidepressant drugs have been shown to be highly successful. Control of enuresis is a secondary effect of these medications, hypothesized to be successful by not allowing the individual to sleep as soundly; thus making him more aware of his body functions. Tofranil is primarily a mood-elevator and when ceased may lead to a mild depression.

The nature of this case lead to the hypothesis that enuresis in the child in question was stress induced. Relaxation training was viewed as a possible treatment approach. In reviewing the literature, relaxation training does not appear as a treatment for enuresis. Education Resources Information Center (ERIC), Psychological Abstracts, and Exceptional Children Data Base (ECDB) yielded no citations.

METHOD

This youngster was completely toilet trained at age three-and-a-half; no accidents ever occurred. At age five, he entered the hospital to have his tonsils and adenoids removed; while hospitalized, nighttime bedwetting began. This averaged three nights per week. The student began school at age six-and-a-half in September 1974, and throughout kindergarten wet beds occurred two and three nights per week. At this time, a medical referral was made and no physical cause was found. Treatment recommended by the pediatrician consisted of ceasing liquids after 6:00 p.m., having the youngster go to the bathroom before bed, and waking him at midnight to relieve himself. This was not successful.

First grade began in September 1975, and the student was enuretic one to two nights per week until December at which time the wetting increased to three nights per week. In mid January 1976, the Iowa Tests of Basic Skills were administered, and this student began wetting his bed nightly. Saturday was often a non-bedwetting night. This behavior continued to average six nights per week until Tofranil was prescribed by the family pediatrician on April 22, 1976. This medication was successful in stopping the enuresis. The medication was removed after the school year ended. The student's parents report a depression for seven to 10 days. This depression was marked by frequent crying and a high level of self criticism. At this time, the parents decided they would not use medication for treatment again.

During first grade, the student was taught to wash his own sheets each day he had a wet bed. He was also responsible for making his own bed. Since then the student independently washes his own sheets and makes his bed after bedwetting. No punishment other than this natural consequence was ever imposed. His parents report criticism was avoided.

Second grade began with no wet beds until December 1976. Throughout December, the student was enuretic two nights per week. Over Christmas vacation he ceased bedwetting. When school began in January 1977, the youngster was wetting two to three nights until the third week of January when Iowa Basics were administered. From this point until school was out in May 1977, he was enuretic at least six nights per week. He ceased bedwetting the day after school ended for the year.

Third grade followed an identical pattern until April 1978 when psychological intervention began. The student's mother was taught relaxation procedures and she used these procedures each night before bed.

The student's mother was taught to have the student tighten or tense the muscles in question, and then have him release them. Each set of muscles was held in a tightened position for 10 seconds and then released. The following muscle groups were involved with this student in the sequence indicated:

- 1) Left hand
- 2) Right hand
- 3) Bend hands back at wrist
- 4) Make fist toward shoulder; make a muscle
- 5) Shrug shoulders
- 6) Wrinkle forehead and brow
- 7) Close eyes tightly
- 8) Clench jaws -- bite teeth together
- 9) Press lips together hard
- 10) Head forward -- bury chin in chest
- 11) Arch back
- 12) Take a deep breath and hold for 10 seconds
- 13) Tighten stomach muscles
- 14) Stretch legs, lift off bed, keep them stiff

The relaxation sequence carried out by the child's mother also included the child being asked to close his eyes and imagine seeing large, fluffy clouds. This imagery would continue for approximately two minutes with the student encouraged to think about floating in the clouds. Imagery was seen as a technique that could enhance the entire process.

RESULTS AND DISCUSSION

It was previously indicated that this student was enuretic six nights per week until April 1978. The relaxation training procedures began on April 11 and continued until April 16 without success. The student realized what the concept of relaxation was on April 17 and he was able to relax one hand. He had a dry bed that night. His mother continued the procedures and gradually the student was able to relax all of the muscle groups. Enuresis did not recur that school year. The relaxation exercises were stopped for the summer without any recurrence of enuresis. The procedures were begun again when the school year started. The student's mother gradually withdrew her involvement and the student would go through the exercises independently before bed.

In December 1978 and January 1979 as the Iowa Basics approached, 10 to 12 incidences of bedwetting occurred. The parents were encouraged to go through the procedures with the youngster before school and at night each day of the Iowa Tests of Basic Skills. Since the Iowa Basics ended in January through March 5, 1979 (the date this paper was written), no bedwetting has occurred. The student is again going through the exercises independently and completes the sequence in five to seven minutes each night.

Breathing exercises are currently being taught to the student to improve his relaxation state. A long term goal is to reduce the amount of time it requires for the student to complete his exercises. This decrease in time could lead to the student being able to go through his procedures in the school setting whenever stressful situations occur. Directly before regular classroom

examinations is a specific time a shortened relaxation procedure would prove to be beneficial.

It should again be pointed out that this youngster was evaluated medically and was found to have no physiological cause for his enuresis. Relaxation training in this case appears to be successful in dealing with stress induced enuresis. A further use with this individual is to develop better test performance through relieving the stress symptoms.

Other applications of relaxation training could include school avoidance in certain instances, general test anxiety, and certain phobias. The professional journals are demonstrating further uses of relaxation training procedures.

DESIGNING SMALL GROUPS AS A RESPONSE TO
LOW-INCIDENCE REFERRAL REQUESTS

James Paul Heider
102. S. Hazel
Ames, Iowa 50010

ABSTRACT:

Low-incidence referral requests involving topics such as death and dying, divorce and friendship were dealt with in small, topical reading groups, counseling groups and social skills training groups.

March 11, 1979

Designing Small Groups as a Response to Low-Incidence Referral Requests

An Abstract

Low-incidence referral requests involving topics such as death and dying, divorce and friendship were dealt with in small, topical reading groups, counseling groups and social skills training groups.

INTRODUCTION

School psychologists and other personnel occasionally receive requests for services to high-risk children, whose problems are common but do not usually result in a formal referral. Perhaps several children in a given school have parents undergoing divorce proceedings or a recent death in the family. Even more might be considered by teachers and peers to lack social skills. However, few of these students are referred to team members.

Once such a referral is received, several responses are available to the school psychologist. She/he might ignore the referral, and hope that it goes away. A referral to an outside a-

gency, pastoral counselor, etc., might relieve the psychologist from the burden of responsibility. Or the psychologist might take matters into hand in some attempt to respond appropriately.

Formal assessment of grief reactions is, at best, problematic.⁵ Social skills deficits might be easily pinpointed and programmed for at the trainable mentally retarded level¹, but educable and normal children, and even the gifted, are sometimes referred for training. Some of these skills are provided in the regular classroom, so any formal training effort needs to be complementary in nature.

Other children, whose social repertoires are adequate, may be referred for various emotional reactions to situations beyond their control⁷. Operant skills training would be less appropriate for these children than would desensitization through discussion of various respondent behaviors, along with the rehearsal of cognitive responses which allay anxiety⁸.

For children whose social-emotional adjustment would preclude active participation in structured skills training, or discussion on a rational basis of material acquired through reading, the use of traditional counseling groups seems appropriate. Depending on the background and preference of the leader, such groups might be supportive or confrontive in nature.

METHOD

- A. With one exception, all groups designed by the author involved children in the upper elementary or junior high grades. The maximum of student motivation and receptivity were felt to be in the fourth and fifth grades. Younger children were difficult to manage in groups, and older students seemed harder to reach. Mixed groups seemed to work as well as same-sex groups, despite the feeling that latency-aged children should be in same-sex groupings.³ One group of pre-teen girls seemed to work well due to homogeneity of background and concerns.
- B. Groups involving more than two or three target children, especially if the referring problem was aggressive behavior, resulted in a "hothouse" effect similar to that found in some ED classrooms. One practitioner⁹ suggested no more than one target child per group to eliminate such possible group reinforcement of deviant behavior. However, when students are referred for deficits rather than excesses of social interaction, such problems are minimized. Other group members were nominated by teachers and/or peers, often as "models" for good social interaction. Some of these children were new to the school, and thus were in a position to bene-

fit from "friendship" groups.² Parent permission was obtained, especially for target children.

C. Goals of the social skills groups were to increase both the number of social interactions within the group and the amount of generalization back to the classroom. Goals of the small, topical groups were to facilitate intellectual understanding of the grief-producing stimulus or motivational problem, and to elicit and desensitize corresponding emotional behaviors. Goals of counseling groups were to promote individual acceptance by the group of target students, and to achieve more responsible behavior through group pressure and confrontation.

D. Specific treatment strategies for the three types of group are as follows:

1. Social Skills Training Group

- a. Test for prerequisite skills
- b. Model and elicit practice of new skills
- c. Provide feedback on performance
- d. Train for generalization

2. Topical Reading and Discussion Group

- a. Find age-appropriate material⁴
- b. Sequence material from less to more threatening⁶
- c. Discuss intellectual content
- d. Share feelings generated

3. Counseling Groups

- a. Get acquainted exercises
- b. Structure the group
- c. Explain how students, including targets, were selected
- d. Solicit cooperation from the group
- e. Allow controlled confrontation
- f. Model sharing and reinforce group sharing
- g. Terminate and set expectations for targets

E. Social skills and topical groups worked better with two or three children at a time. Counseling groups were larger, with six to eight children maximum. Length of sessions averaged forty minutes for older children and larger groups. Small, topical group sessions often were limited to twenty to thirty minutes. Six to eight sessions were necessary for counseling groups and social skills training.² Two to three sessions were sufficient for topical groups, with follow-up as needed.

RESULTS

Social validation was the main basis for evaluation of treatment outcome. The use of aides as observers may have provided a more objective evaluation system.⁸ Administrative support was provided by several elementary schools in Des Moines and rural Story County. Improved relationships with co-workers, including

school social workers who co-led some of the counseling groups, was an unexpected bonus. Exposure to unique training experiences was provided for at least three school psychology interns.

DISCUSSION

The school psychologist, although necessarily valued for traditional assessment skills, has many treatment modalities available for use with both high and low-incidence referral requests. Different training emphases and personal preferences might contraindicate the involvement of school psychologists in group work. However, the obvious cost-effectiveness of working with groups of children, as opposed to spending hours in evaluation of individuals, is worth trying new techniques. The teachers, children and parents, and especially the psychologist, will be massively reinforced for such efforts.

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THOUGHTS ON THE RELATIONSHIP OF ADULT
ATTENTION TO CHILD BEHAVIOR

Mark S. Shepp
226 North Best Street
Forest City, Iowa 50426

ABSTRACT:

A case study is described in which a nine year old third grade female (Rachelle) is the client. This girl was seen by this psychologist for counseling due to family relationship problems for a period of three months during the 1977-78 school year. Concurrently, a Northern Trails Area Education Agency social worker worked with the family as a whole unit. At the end of that school year, the initial problems had been resolved. During the 1978-79 school year, Rachelle again came to this psychologist's attention due to a reluctance to finish arithmetic work in the classroom. Through the judicious and economical application of this psychologist's attention as a contracted reward for doing a minimal amount of math work, Rachelle's "doing arithmetic seatwork" behavior soon "successively approximated" the teacher's expectations. In the discussion, consideration is given to the appropriate application of adult attention and reinforcement in general.

March 30, 1979

THOUGHTS ON THE RELATIONSHIP OF ADULT
ATTENTION TO CHILD BEHAVIOR

ABSTRACT

A case study is described in which a nine year old third grade female (Rachelle) is the client. This girl was seen by this psychologist for counseling due to family relationship problems for a period of three months during the 1977-78 school year. Concurrently, a Northern Trails Area Education Agency social worker worked with the family as a whole unit. At the end of that school year, the initial problems had been resolved. During the 1978-79 school year, Rachelle again came to this psychologist's attention due to a reluctance to finish arithmetic work in the classroom. Through the judicious and economical application of this psychologist's attention as a contracted reward for doing a minimal amount of math work, Rachelle's "doing arithmetic seatwork" behavior soon "successively approximated" the teacher's expectations. In the discussion, consideration is given to the appropriate application of adult attention and reinforcement in general.

INTRODUCTION

The many effects of the application of simple adult attention on children's behavior have long fascinated this writer. While this technique is the most economical in the sense of how valuable time is spent, it is also perhaps the most misapplied technique around. The following would be a prime example of its misapplication: A fourth grade boy with no access to the attention of adult males at home acts out aggressively on the playground and is sent to the principal's office to be either given a "fatherly talk" or a "dressing down."

The purpose behind such action is to stop the acting out on the playground but it could just as easily be reinforcing the undesirable behavior. It may seem paradoxical to some that being "dressed down" (a euphemism for being yelled at) would, in some cases, not stop but encourage a certain behavior. This seemingly paradoxical situation can be clarified by recounting the "Soggy Potato Chip Parable." Simply stated -- "If the child is very hungry and there is nothing else to eat in the house but soggy potato chips, he will eat those rather than go hungry." If a child is starved for attention and cannot get positive attention, he will strive for negative attention over none at all.

Also applicable to the above mentioned example is the fact that a "fatherly talk" can also have the effect of reinforcing the acting out on the playground. The application of adult attention after inappropriate behavior has occurred, while it is probably the most commonly used discipline technique, is fraught with perils. You may wind up with just the opposite results from the one desired (i.e., increase in undesirable behavior instead of decrease).

How does one go about not falling into this trap? Well -- "Pay attention to them (reward them) when they are doing what you want them to do." More seriously and more professionally stated, the most efficient and effective way to modify an undesirable behavior is to deliver a reinforcement when the organism is emitting an incompatible desirable behavior and stop delivering reinforcement for the undesirable behavior (i.e., temporally contingent time out). This is the general methodology used with Rachelle regarding her behavioral deficit in the arithmetic seatwork area.

METHOD

A. Rachelle, now a nine year old third grader from a midsize Iowa school district, first came to my attention in the 1977-78 school year because of minor behavior problems at school and conflicts with peers and parents at home. During that time, counseling was done with Rachelle herself and

with Rachelle and her parents to clear up various misconceptions held by children and adults in the family, to train the adults in the family in the use of more effective parenting techniques, and to be more assertive with the children. By the end of the school year, these initial difficulties had been resolved. Rachelle was evaluated prior to the onset of treatment and found to be of average intelligence and with appropriately developed academic and perceptual motor skills.

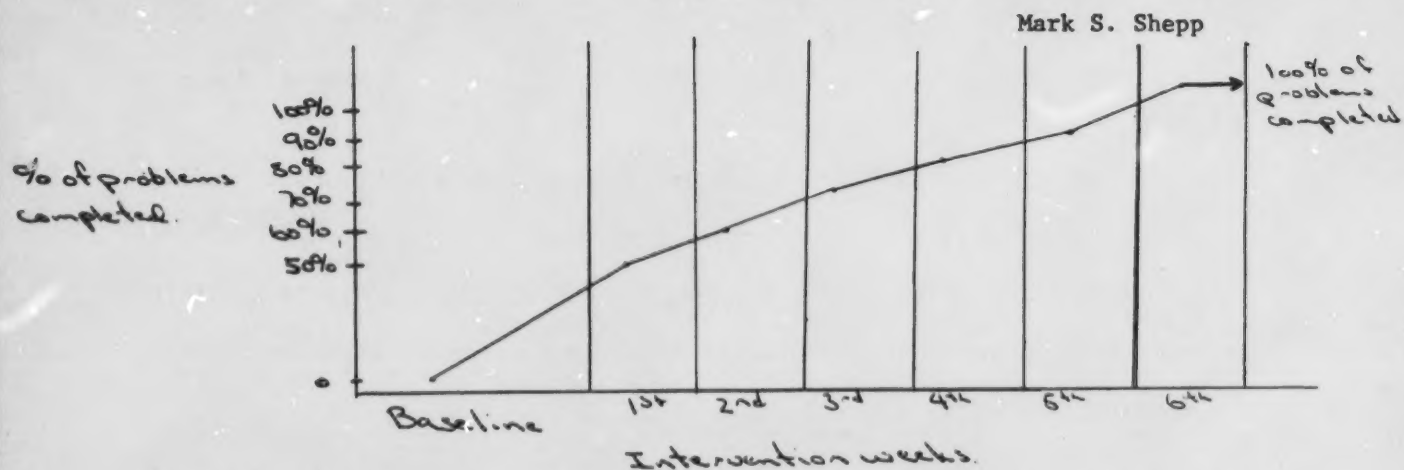
- B. Rachelle's teacher approached me the following year because she said she knew I had "worked with" Rachelle last year, and told me that Rachelle was "having problems again." An appointment for a more lengthy discussion was made for the following day. During this discussion, this psychologist assisted the teacher in operationalizing Rachelle's problem, and it was discovered that she was simply not finishing and handing in arithmetic drill work. It was further ascertained that no real problem behaviors were evident and that Rachelle's teacher had spent a good deal of time with her in an attempt to cajole her into doing her work. The work Rachelle was being asked to do was considered to be well within her range of skills and capabilities. A phone call to Rachelle's parents was made, and they bore witness to the fact that she was behaving appropriately at home and that the family was working well as a unit. It was decided that Rachelle's current problems were probably attention related and not a recurrence of the previous difficulties. The deficit in drill work behavior was treated essentially as an isolated problem. If it had not responded well to treatment, other considerations as to a more complicated set of contingencies would have been made.
- C. The goal of the intervention was simply to increase the number of drill work problems done daily from a baseline of zero to 50% of those assigned initially, and then gradually to 100% of those assigned. In this manner,

the teacher's expectation of Rachelle (100% of problems done) was soon met through successive approximations of that goal. The criterion of successful completion of the problems was not included, since it was felt that Rachelle had the skills to get the problems correct once they were produced.

- D. The specific treatment strategy used was essentially behavioral in nature. Through a contractual agreement, this psychologist's attention was made available to Rachelle if and when she completed the terms of the contract. This writer's attention was used because it was previously observed to be reinforcing for Rachelle, and Rachelle herself had verbally confirmed this. The contract was handled in a very formal manner with the school principal being designated as "witness" and "cosigner." The contract provided that, if Rachelle met the criteria for success (50% of problems done daily for five days), she could earn 10 minutes with this psychologist to discuss whatever she cared to. The criterion of 50% was chosen because it was felt that this was one which Rachelle could easily attain. If a goal is set beyond a child's reach, it is obviously useless. The initial criteria was set at 50%, as mentioned above, but was revised upwards at 10% intervals every two weeks. It was planned that, once the maximum criteria (100% of problems done) had been reached and reinforced by two visits, the reinforcement visits would be faded to every two weeks, then every four weeks, and then "out" entirely.

RESULTS

As might be expected from the simple design and the apparent absence of other compounding problem variables, Rachelle easily attained each successive approximation of 100% of her math problems done. If charted, Rachelle's progress would appear like this:



As mentioned before, such neat and precise progress was no doubt due to the lack of confounding variables. After 100% success (all problems finished) had been reached, reinforcement was delivered two weeks successively, and then gradually faded. Periodic followup has shown no recurrence of problems in doing arithmetic drill work.

One question which should be addressed in this situation is just -- "Who has who conditioned and in what way?" It has occurred to this writer that Rachelle might, in the future, know just how to get my attention. As a matter of fact, that may have been her objective from the start. Looking at the situation from the "big picture", this entire intervention may have reinforced Rachelle's noncompliance with her teacher as far as doing math drill work. To a psychologist who looks at clinical situations from a behavioral point of view, this can be a rather frightening realization.

DISCUSSION

It is obvious that the problem outlined here was efficiently and effectively solved but that wider implications are involved than this rather simple clinical situation. As mentioned above, the possibility exists that any intervention into attention related behavior problems may reinforce the very maladaptive behavior that it intends to eliminate. In a clinical situation, that seems to be a risk which must be run. Attention seems to be a fairly cheap commodity, however, (especially in the five to 10 minute range) and

efficient to use. In the schools (and elsewhere) it should be a readily accessible and easily used motivator and easily transferred or generalized between people. In the case study dealt with here, if Rachelle showed up with another attention related behavior problem, it should be possible to generalize the reinforcing qualities of this psychologist's attention to other more appropriate and accessible individuals at school and at home. This is the way this problem would be dealt with should it arise.

Another issue that must be dealt with, both in the schools and in the human community at large, (one which is touched on in Skinner's Beyond Freedom and Dignity) is that of whether it is better to apply attention to people or children when they have entered the realm of deviance or to apply attention to humans when they are engaged in appropriate and adaptive behaviors. In other words, is it better to catch human beings being good or to catch them being bad? To focus on the schools, not to say that other parts of society are not culpable, it seems that the one time a child can be assured of receiving attention, whether it be positive or negative, from a number of adults, is the time that he or she steps across the line of what is acceptable and what is not -- over to the "not" side. Kids rarely get recognized in any way for being good -- this is to be expected. However, let a kid be "bad", and it seems as if the world converges on him or her. As we have discussed before, the result of that attention may be the very antithesis of what was desired (i.e., reinforcing the maladaptive or "bad" behavior).

This is not to say that isolated clinical cases should not be attended to since, to a certain extent, we are locked into that model. This is to say that from the other side of the coin it would be more adaptive if educators and many others would begin to look at reinforcing kids for "expected" behaviors or doing what a kid should do. We know from the data available on modeling technology (Bandura, 1969) that this need not be mass reinforcement of all

kids, but engineering its delivery to a few would have a beneficial effect on the behaviors of many of the others. In the opinion of this psychologist, the shift in sets from catching kids being bad to catching kids being good would be difficult for schools as entire systems, but once accomplished would provide a less pressurized, less negative, and more desirable and adaptive environment for all who spend time there -- children and adults.

Well, this began as a case study and grew into an editorial. My apologies to Jeff but it was almost beyond my control. I hope our thoughts and discussions on this subject do not conform to the truism, "When all is said and done...more is said than done."

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A BEHAVIORAL APPROACH TO TREATING
VOLUNTARY MUTISM (OR "NEAR APHONIA")

Bradley W. Rasch
Arrowhead Area Education Agency
916 Superior Street
Webster City, Iowa 50595

Abstract:

A reserved fourth grade boy who could adequately make all appropriate sounds and who also had adequate language development was treated for aphonia. Shaping was used to develop speech of normal intensity.

January 15, 1979

A Behavioral Approach to Treating
Voluntary Mutism (or "Near Aphonia")

Introduction:

Aphonia is a rare problem that is seldom brought to the attention of School Psychologists as well as Speech and Language Clinicians. Aphonia, of course, is not a problem of delayed language or speech development. The problem is the reduced intensity used in talking. Aphonics speak in a hardly audible whisper. In many cases, the etiology of this problem is unknown.

Method:

A ten year old boy whom we'll call Mike had communicated in a soft, raspy voice since he had attended school. This problem was confined mostly to school, in that he would, at times, talk with a higher intensity at home. Mike's parents and teachers were not alarmed by this behavior in that they saw Mike as being a "very shy" boy. Since Mike's behavior appeared to be voluntary (in that he spoke softly at school, but did not always speak softly at home) it might more appropriately be called "near aphonia."

Since Mike appeared eager to please, it was thought that behavior might be shaped through attention, praise, and kindness. The ultimate goal of the

program was 100 per cent normal voice intensity by Mike while at school.

At first, Mike and the author would hum together. When Mike's was louder than the author's, praise, of course, would be lavished upon Mike. Then, Mike would hum alone; when the intensity increased, lavish praise, an obvious reinforcer, was heaped upon Mike.

Next, oral reading was tried. The intensity gradually improved to what appeared to be normal intensity after much praise had been given.

Results:

Mike's successes did not readily generalize to his conversational speech in a non-contrived situation. Gradually, with the help of teachers, and other personnel, Mike found reinforcement for increased intensity while in school. By using successive approximations, the intensity was shaped to the point that it appeared to be "within normal limits" while Mike was in school. The goal was accomplished in 12 visits with the School Psychologist and considerable support from the staff. A follow-up is planned. Hopefully, the change in Mike's behavior will be permanent.

Table 1

- Day 1 humming (with E).
- Day 2 humming (with E and alone).
- Day 3 oral reading with E.
- Day 4 oral reading with E.
- Day 5 oral reading with E.
- Day 6 oral reading with E.
- Day 7 oral reading with E.
- Day 8 oral reading with E.
- Day 9 oral reading with E.
- Day 10 oral reading with E and staff support.

Day 11 oral reading with E and staff support.

Day 12 oral reading with E and staff support.

Follow-up planned.

Discussion:

The treatment involved shaping Mike's behavior. The response approximations were reinforced with attention and praise. Response approximations were reinforced within each topography and across topographies. The target behavior of normal speech intensity in school was achieved. The method of successive approximations appears to hold promise as an approach to be used with other problems.

MODIFYING THE BEHAVIOR OF A BOY WITH MULTIDISABILITIES
IN A DEVELOPMENTAL LEARNING CENTER

Emily Ann Jackson, School Psychologist
Jeannette Fredericks, Speech Clinician
Bernadette Luebe, DLC Teacher
Pat Johnson, Teacher Aide
Arrowhead Area Education Agency
Storm Lake, Iowa 50588

Abstract:

Using the reports available, home visits, interviews and classroom observations, the DLC Team, consisting of: Teacher, aide, speech clinician and school psychologist, formulated goals and exchanged methods needed to provide the structured environment necessary to modify the behavior of a five year old boy with multidisabilities.

February, 1979

MODIFYING THE BEHAVIOR OF A MULTIDISABILITY
BOY IN A DEVELOPMENTAL LEARNING CENTER

Introduction

Harold (not his real name), the youngest of four children, was born when his mother was age 40. There is a fifteen year differences between Harold and the next youngest sibling. The father and other adults in the home, not including the mother, refuse to accept any responsibility in helping with Harold.

Methods

The primary methods used to develop a program for Harold in the Developmental Learning Center were: previous reports, present testing, classroom observation, exchange of methods and information among the disciplines involved.

When Harold was approximately three years old, he was evaluated at Glenwood State Hospital School. The medical diagnosis concluded: mental retardation (origin unknown) and hyperkinesis. Harold's behavior at the time of the evaluation precluded anymore extensive evaluation.

Initial observation of Harold at the DLC revealed behaviors which were interfering with his ability to learn. Harold was unable to attend - he wandered from area to area within the classroom. When made to sit for music or other subjects, he did not participate, instead he would crawl

around on the floor moving from the teacher to the aide and back, he talked, interrupted other children. The same behavior occurred during gym class and formal language lessons.

During naptime, he was either unable or unwilling to rest. He was removed from the room and his mat placed outside in the gym area with the teacher or aide staying with him. He would frequently be up and down, talking to the adult present or himself.

His speech was, for the most part, unintelligible. Many articulation errors were noted. The bulk of Harold's utterances fell within a limited set of phrases which he used over and over in a perseverating manner. He also displayed some echolalia.

Harold seemed to use these key phrases to give a more rigid structure to his activities and as a kind of self-reinforcer for what he was doing.

When displeased or unwilling to do tasks, he would have temper tantrums consisting of loud perseverating remarks, hitting, kicking, crying and rolling on the floor. Harold's behavior towards the other children included touching them with his mouth, staring in their faces or sitting in front of them.

Both the psychologist and speech and language clinician found formal testing impossible.

Since it proved difficult to implement behavior modification plans through the home, it was decided to concentrate on changing the school behavior.

Most of the programs developed to modify Harold's behavior grew out of "brainstorming" sessions with the DLC Preschool Team: teacher, aide, speech and language clinician, and school psychologist.

Results

For some reason, unknown after investigation by the staff and interviews with the parents, Harold's behavior changed drastically in late October.

The staff felt these changes may have been due to a change in babysitters or an increase in communication skills. During this time, Harold's cognitive skills also increased. Now he could count, recognize numerals, identify shapes and colors.

Given Harold's communication deficits the Hiskey Nebraska Test of Learning was tried. All subtests were attempted but only Bead Patterns and Paper Folding were scoreable (both 3.6). All that could be discerned from this test was that Harold's imitative ability was good. (This test led, in part, to the decision to use key phrases.)

Harold was now participating in group 75% of the time, napping 50% of the time, hitting was reduced to a once a day average, rolling on the floor, running away, crying and screaming were all discontinued.

In November, Harold's problem behaviors began to reoccur. The only environmental change the staff could determine was a change in babysitters again. It is interesting to note, however, that his cognitive abilities continued to develop.

Throughout the rest of the year, Harold's behavior remained inconsistent. From observations, however, it was concluded that for every step back Harold took two steps forward.

In the end of November 1978 various subtests of the WPPSI were readministered. At this time, Harold showed an increase in vocabulary, less perseveration and more intelligibility. Though unable to point out missing elements in Picture Completion, he was able to name each picture or something in it.

It was agreed that two behavior changes were necessary before any learning could take place: 1) reduce temper tantrums thereby increasing attention span 2) increase his communication skills.

A variety of methods were attempted to reduce temper tantrums. Each followed a similar pattern: after an observation period when the behavior was counted and recorded, there followed the implementation phase. When each modification was introduced, it would appear successful. The number of tantrums would be reduced. Invariably, however, after approximately two weeks the problem behavior would increase in frequency. The various techniques attempted included: reinforcement of good behavior, hugs and back rubbing to calm him down, candy, playing "mousies" (a game Harold particularly enjoyed - it consisted of walking fingers up and down his arm), time out on a chair, shoulder grasp.

Harold was watched carefully to see which children and/or activities he responded to most favorably, hoping this would provide some clues for reinforcement. Harold never showed consistency in his choices.

To increase communication skills, the number of key phrases Harold used was increased - most of these phrases were coupled with task oriented behaviors. These key phrases were likewise reinforced with hugs, verbal praise and applause.

Harold was 4-9 when the Berry Test of Visual Motor Integration was administered. He received a score of 4-1.

In early October, a WPPSI was attempted. During the testing period, Harold was unable to attend for any length of time. Each subtest was attempted. Only the Animal House subtest was scoreable (9). The Verbal subtest could not be scored because of his unintelligibility and perseveration. The Performance subtest proved difficult for Harold was unable to either comprehend or follow the directions.

He was also able to follow directions on the Arithmetic subtest. He was more responsive to personal interaction, smiled appropriately, showed less distractibility, more interest and responded to praise.

At this time a Burke's Behavior Rating Scale, rating by the teacher, (Preschool and Kindergarten Edition) indicated one very significant area: poor intellectuality. Significant areas included: excessive anxiety, excessive withdrawal, excessive dependency, poor ego strength, poor attention, poor impulse control, poor reality contact, excessive suffering, poor anger control, excessive resistance.

Discussion

At the time of this report, new testing had not been completed. Behavior, though inconsistent still, is no longer as unpredictable or uncontrollable as in the past.

Toilet training has been completed, eating and other social skills show improvement, cognitive skills are increasing.

No conclusion on the part of the team, has been drawn as to Harold's possible mental retardation. It is the assumption of the team that environmental deprivation combined with emotional and communication disabilities prevent the use of standardized instruments to make this determination.

In the future, the Developmental Learning Center Preschool Team will continue to act as a unit to structure Harold's environment to help him make gains in all those areas which show deficits.

**MEDICATION—AN EFFECTIVE TREATMENT
OF HYPERACTIVITY**

**Ralph J. Worthing
Area Education Agency #6
Hardin County Office Building
Eldora, Iowa 50627**

Abstract:

A twelve year old, fourth grade student diagnosed as hyperactive was evaluated both when he was not taking medication and when taking 40 mg. of Ritalin a day. A significant improvement was noted on cognitive and fine motor tasks when the student was on medication.

March 29, 1979

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Introduction

The journal literature is replete with studies pertaining to overactive children. Among these writings are contradictions and controversies in regard to the etiology, nomenclature, and treatment of the malady. The terms hyperactivity and hyperkinesis are perhaps the most widely used of all descriptive labels, with each having different connotations as to the cause of the syndrome. Hyperactivity is more often seen as having developmental or psychogenic roots (Howell, et al., 1972; Lightfoot, 1973; Schmitt, et al., 1973) while hyperkinesis, which literally means abnormally increased muscle movement, infers neurological impairment (Bax, 1972; British Medical Journal, 1973; Goddard, 1973).

The question addressed in this case study, however, is not nomenclature, but the effects of medicinal intervention in the treatment of the syndrome. Such treatment of the problem is also a moot point and gives rise to arguments both for and against its use. Various negative side-effects, such as suppression of height and weight growth, are cited (Safer and Allen, 1973; Nutrition Review, 1973) as well as the theory that drug treatment is often implemented as a unilateral approach, thereby reducing the incentive of the child to control his/her own behavior (Williamson, 1972). Despite the possibility of these harmful side-effects, medication is seen as a viable treatment for excessively high activity levels in children and continues to be the predominant treatment for the same (British Medical Journal, 1973; Howell, et al., 1972; Schmitt, et al., 1973).

Method

Brian is a twelve year old, fourth grade student with a history of hyperactivity. (The usage of the term hyperactivity is chosen here largely because

it is felt that Brian's problem is not contained within the domain of muscular activity. He also manifests highly distractible behaviors which are not necessarily accompanied by kinetic movements.) He was diagnosed as such very early in his educational career and has been on medication (Ritalin) of varying dosages since then.

At the beginning of the 1978-79 school year Brian was taken off medication by his parents. While off the Ritalin, Brian was evaluated as per the requirements for continued resource room placement. The results of this examination included a WISC-R Verbal Score of 72, a Performance Score of 73, and a Full Scale I.Q. of 71. Brian was also administered the Bender-Gestalt Test for Young Children and the Human Figure Drawing Test (HFD). On both the Bender-Gestalt and the HFD a great deal of impulsivity and poor inner control was evident (see Figures 1 and 3). These tests, along with classroom observation, revealed a boy who exhibited a great deal of distractible, non-functional behavior which had a detrimental effect on his acquisition of knowledge. Brian was absolutely unable to maintain attentive (i.e., on task) behavior for a period exceeding one minute.

Approximately one month after medication was discontinued, Brian's Ritalin was reinstated at a dosage of 10 mg. taken four times daily. The medication was dispensed before school, at ten a.m., at noon, and after school. Four months subsequent to the reintroduction of Ritalin, Brian was reassessed to determine what effect, if any, this particular treatment had on Brian's behavior. This evaluation included the administration of the Stanford-Binet Intelligence Scale (1972 norms) and the re-administration of the Bender-Gestalt and the HFD.

Brian

Ralph J. Worthing

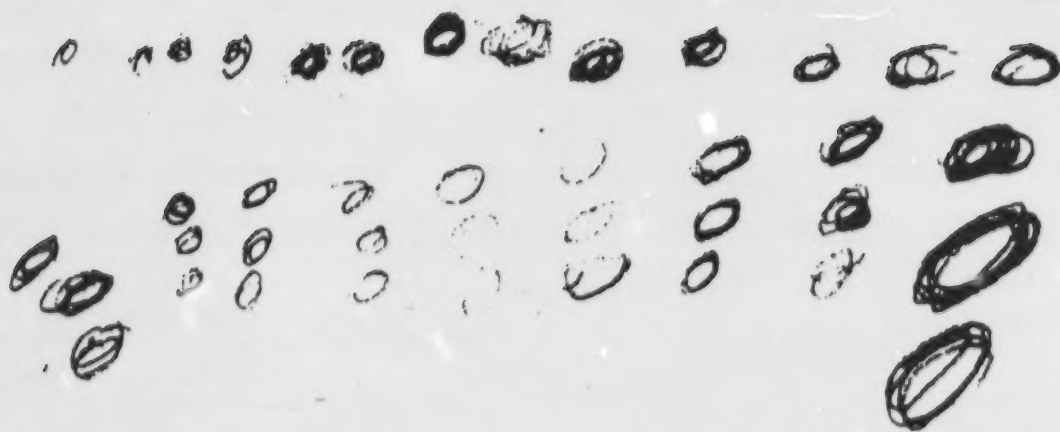
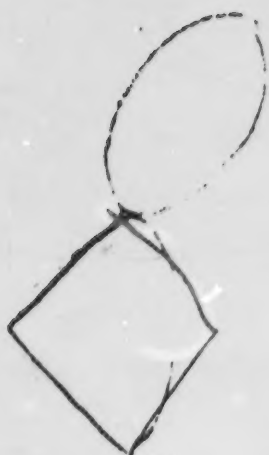


Figure 1

Brian



Figure 1

Brian

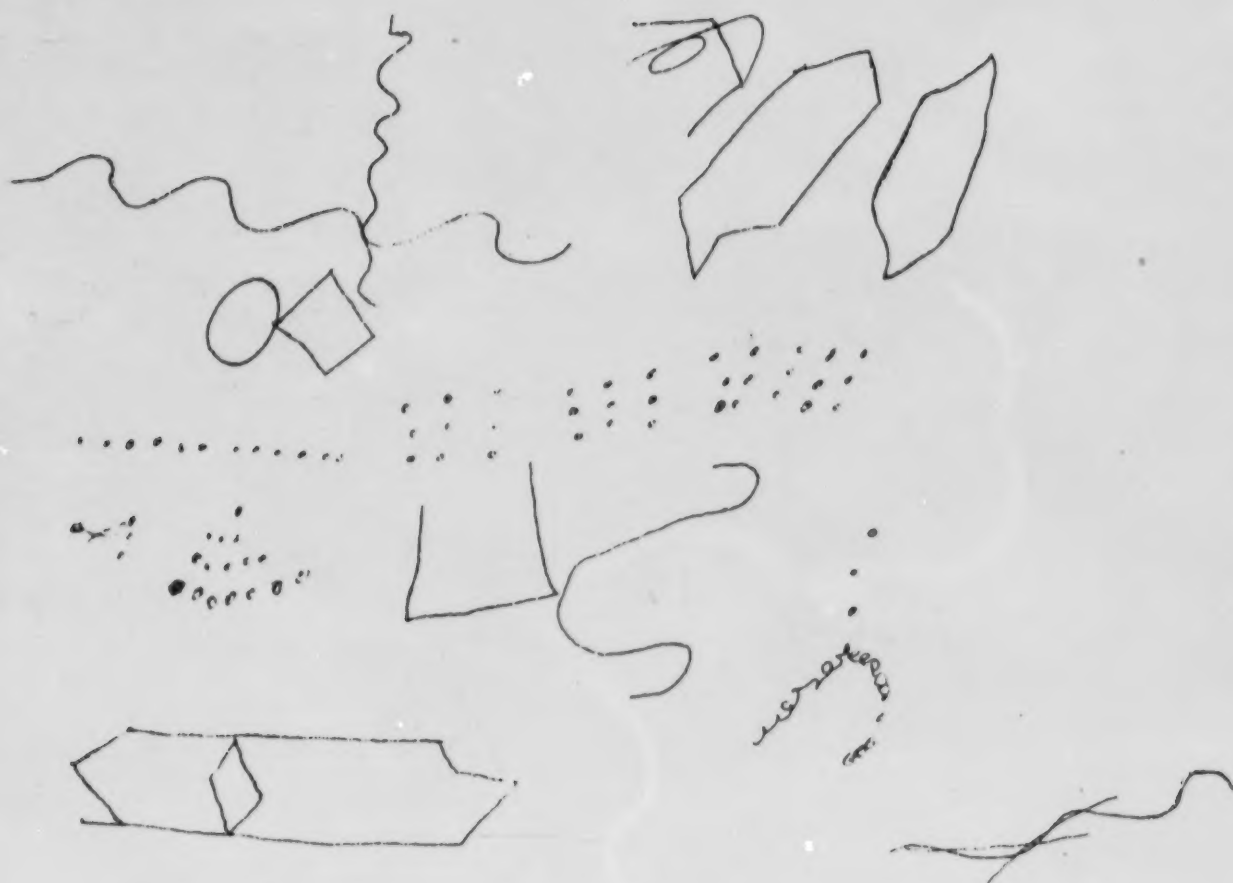


Figure 2

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Brain



Figure 3

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Brian



Figure 3

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Brian



Figure 4

Results

On this second evaluation Brian obtained a Stanford-Binet I.Q. of 81, which showed a ten-point increase from the previous WISC-R Full Scale I.Q. His drawing tests indicated marked improvement as well. On the first Bender-Gestalt (Figure 1) Brian was unable to contain himself to one page, but while on medication he limited himself to one-half of a page (Figure 2). Similarly, his first HFD (Figure 3) required two attempts, with the final result a large figure with a great deal of shading and overwork, while his second drawing (Figure 4) was noticeably more controlled. Special note is also given to Brian's writing of his name. Again, a significant difference was evident between the first evaluation and the second in the quality of Brian's writing.

A noted improvement in Brian's behavior was observed by both his regular classroom and resource room teachers when medication was reinstated. He was able to concentrate much better and was not troubled nearly as much by non-functional, distractible behavior.

Discussion

The difference of ten I.Q. points suggests an improved ability to concentrate on and respond to complex cognitive tasks. The Stanford-Binet I.Q. obtained on the second evaluation correlates closely with previous testing done when Brian was in second grade. At that time he obtained a Verbal Score of 82, a Performance Score of 80, and a Full Scale I.Q. of 80 on the WISC-R. He was on medication during this prior assessment. In view of these findings it would appear that Brian, while on medication, functions at an ability level in the low 80's, but when off medication his level of functioning is depressed somewhat. The difference is a student in the Low Average range of intellectual functioning as opposed to Borderline intelligence.

The most concrete evidence indicating a difference in Brian's behavior under the two conditions, however, is a comparison of his drawing skill during these times. The Bender-Gestalt and the HFD provide undisputable evidence that Brian is much more controlled in his actions when on medication than he is when medication is discontinued. This observation is substantiated by the difference in Brian's behavior noted by his teachers.

The conclusion drawn here is that Brian is a boy who is unable to perform adequately in a school setting without medical intervention. Without medication Brian would not be able to assimilate the information presented in his classroom and consequently would not master the basic skills necessary for future success in school. It is felt that the concern regarding Brian's acquisition of knowledge overshadows the potential--yet not certain--negative side-effects of medication.

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**CHRONIC ABSENTEEISM
THE PERPLEXING PROFILE!**

**K. T. Hinkle
1509 Olde Hickory Road
Coralville, Iowa 52241**

Abstract:

This case study depicts the importance of surveying attendance data as an integral part of the diagnostic procedures employed by the school psychologist.

March, 1979

Introduction

Much has been said but little written concerning the chronic absentee student. This, in spite of the fact that absenteeism has historically been viewed as one of the most provocative issues confronting education. In fact, absenteeism is considered to be the most troublesome day-to-day problem facing administrators¹ of secondary schools.

Over time a profusion of administrative, legislative and therapeutic strategies have become common practice in attempting to curb the rate of absenteeism from school. However, this enigma continues at an alarming rate. As a means of bolstering the defense in the war on absenteeism, support personnel have been recruited into the battle. But, like other strategists, the insight and tactics commonly employed by counselors and/or psychologists have had little if any² positive effect.

In this writers opinion, part of the reason for such poor results is the perplexing profile presented by the chronic absentee student. To help untangle this complex portrait, research and case study data seems essential. It is hoped that through such procedures, a manageable set of images can be developed that will allow us to make sense out of what otherwise appears to be too complex, too diverse, and too evasive to be understood-let alone to treat effectively. With this goal in mind, the following case study is presented.

Chronic Absenteeism Defined- Throughout this article the term chronic absenteeism shall refer to a chronic pattern of absence from school for reasons which are suspected as being other than medical, and which deviates significantly from the established pattern of attendance for a given school community.

Case Study

Susan is a 13 year old, 7th. grade special education student (M.D.-E.M.R.) who had been in attendance at a urban junior high school for only a brief period (six days) before she began to refuse to attend. Susan was quite adamant about her school refusal, exhibiting considerable resistance to returning to school, via threats of self-destruction, as well as, projecting hostility towards school officials. Administrative directive, threatened legal action and counseling interventions failed to show positive results. It was at this point that psychological intervention was requested, through a referral which consisted of three questions:

1. What is Susan's ability?
2. What is the cause of her absenteeism?
3. Why is she so resentful of school personnel?

Cumulative records indicated that Susan was retained in kindergarten due to learning and social difficulties. Susans' inclusion in special education began in 6th. grade. In order to participate in special education it was necessary for Susan to attend class outside her local school district.

Results

In answering the question of ability, previous test data was of obvious importance. It was found that several measures of intellectual functioning had been utilized: two administrations of the WISC, one group measure-Lorge-Thorndike, as well as three language assessments-Peabody Picture Vocabulary Test. To supplement the above measures the Peabody Picture Vocabulary Test, Benton Visual Retention Test and Vineland Social Maturity Scale were utilized to estimate Susan's intellectual and social functioning. Both the PPVT and Benton results were consistent with previous findings, suggesting that Susan's measured ability fell within the borderline range.

In contrast, however, the Vineland results (using the mother as the informant) suggested that Susan's social skills were well above that of a slow learner, and in fact, reportedly above her chronological age. While subjectivity and instrumentation could account for the latter results, interaction with the Susan's parents supported the belief that, at least to her parents, Susan's social skills were perceived as normal for her age and family.

A screening of basic skills (cumulative, informal and formal assessment) found Susan's achievement significantly behind her grade placement (3rd. grade achievement). In summary, based upon compiled data (ability and achievement), Susan's scholastic abilities were found to be significantly below that expected for her chronological age and present grade placement, yet consistent with estimated ability within the dull normal to borderline range (80-70 I.Q.). As a final note, it was evident that Susan had historically been resistant to testing, causing the obtained results to be subject to cautious interpretation and therefore only reflective of her test and/or school performance and not necessarily indicative of her general social (home/community) functioning.

According to school records, Susan had missed a total of 226.5 school days (1.25 school years) through the sixth grade. Susan's mean rate of absenteeism, prior to her placement in special education, was 24 days/yr., as compared to 58 days missed when she transferred to a special program. While her rate of absenteeism may be suspected as being attributable to learning problems, a comparison of Susan's attendance pattern (while in attendance in her local community and not in special education) to three older siblings (none of which having recorded educational handicaps) was informative:

SUSAN(7th)
24da/yr

KEITH(11th)
25da/yr

SHIRLEY(10th)
25da/yr

KELLY(h.s. grad.)
24da/yr

One can see the remarkable similarity between Susan's absenteeism and that of her siblings. In light of this fact, one would obviously have to question low ability (I.Q. and/or achievement) as being the cause of her chronic absenteeism. Rather, it would appear that Susan's absenteeism, like that of her siblings, was indicative of a set pattern of behavior, attributable to factor(s) inherent in the family structure itself.

Susan's hostility toward school officials appeared to be situationally based (school refusal) rather than a generalized behavioral pattern. In this manner, one could view much of her actions as reactions, responding to persons and/or places in her immediate environment. Based upon cumulative records, observation, formal assessment as well as family history, it seemed more appropriate to characterize Susan's emotionality as being disturbing to others rather than indicative of emotional disturbance (pathology). Susan's threat of self-destruction, as well as hostile manner, reflect the extent, given Susan's social and intellectual maturity, to which she was willing to go to maintain control of her home and school settings. Therefore, in answering the third referral question, Susan's behavior was viewed as an effort to control her home/school situation, rather than indicative of generalized hostility towards school officials or her self.

Conclusions

In summary, Susan appeared to be a student of minimally borderline intellectual ability, whose social and emotional behavior reflected an immature effort to control her school and home environments. Present, situationally oriented, difficulties appeared to be more of a social-conduct type rather than a learning problem per se. Because of the historical nature of Susan's behavior (control) the prognosis of her returning to school, and adjusting to a regular/special class setting appeared poor.

Discussion

From this psychologists' perspective, chronic absenteeism was considered to be Susan's primary disability, confounded by learning difficulties. Susan's hostility was viewed as a situationally specific response aimed at winning control over her school attendance. In this examiner's opinion the above case suggests the following:

1. Low ability (I.Q. and achievement) are not necessarily causal factors in cases of chronic absenteeism.
2. Longitudinal data concerning attendance should be considered an integral part of the information collection and treatment procedures utilized by the school psychologist.
3. Attendance records of the subjects (students) siblings may add important diagnostic information.
4. Control seems to be a common theme in cases of chronic absenteeism.
5. Additional research needs to be conducted dealing with the subject of chronic absenteeism.

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KTH/79

THE GAME: A GROUP CONTINGENCY MANAGEMENT
STRATEGY FOR
INCREASING ON-TASK BEHAVIOR

Alan M. Becke
AEA9 - Service Area I
Clinton, Iowa 52732

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ABSTRACT: A game technique utilizing peer influence, team points and backup reinforcers has been proven effective in modifying group behavior. The following study is a modification of a teacher administered contingency management program. Intervention data shows a significant decrease in off-task behaviors, when compare to baseline. Also, observations when the game was not in effect showed generalization of appropriate behaviors to non-game situations.

THE GAME: A GROUP CONTINGENCY MANAGEMENT
STRATEGY FOR
INCREASING ON-TASK BEHAVIOR

Introduction

Several investigations (Barrish, Saunders and Wolf, 1969; Harris and Sherman, 1973) have demonstrated the effectiveness of "good behavior games" in reducing disruptive, out of seat behavior and talk-outs. Such studies utilized class rules, team points and peer influence to reduce disruptive behaviors in the classroom. This current study is a modification of an approach developed by Darsh and Phillip, 1977.

Method

The subjects in this study were 14 elementary school students currently assigned to a prefirst grade classroom. The students were initially screened for this program depending on an adjudged lack of academic readiness and social skill deficits. The population consisted of 11 males and 3 females. Behavior was observed by the classroom teacher during classroom hours, during four 10-minute intervals; two in the morning and two in the afternoon. During baseline data collection no attempt was made to modify the instruction, content or style. For the purpose of this study, "on-task" behaviors were defined as:

- a. students keeping eyes on the teacher while he/she is giving directions,
- b. students working on assignments,
- c. students raising hands before asking questions.

"Off-task" behaviors were those exhibited by students that did not fall into any one of these three items.

Data was collected during both morning and afternoon periods. The rationale behind this observation strategy was to attempt to assess any generalization effects in the game playing over non-game periods.

The observational scheme utilized by the classroom teacher involved random scanning during selected time intervals and a simple frequency tally of off-task behaviors. This observational strategy was employed during baseline and intervention phases of the experiment.

For the purposes of the game the students were divided into four competing groups. These teams were equivalent to already established working groups in the classroom. The students were told that they would be playing a "good behavior" game with each other. The students were informed that a timer would go off five times during the game. If an entire team was working when the timer went off, that team would receive a point. The students were also instructed as to what constituted on-task performance. The students were also informed that more than one team can win the game. The game was set to be played in the morning during a 30-minute interval selected by the teacher. Five cards were utilized by the teacher to set off the timer. The cards were on a random interval of 6 minutes. The students were told that if a team collected all 5 points they would win. The reward for the winning teams was to be determined by the teacher.

The teacher was also instructed to ignore minor classroom disruptions, and praise the children for appropriate behaviors.

The purpose of this was to maintain on-task behaviors even when the game was not being played. The teacher was instructed to observe the class during the game and during an interval when the game was not being played; noting the frequency of "off-task" behavior in both cases.

Results

After the collection of baseline data, two separate intervention strategies were employed (see chart). The first involved immediate reinforcement on a daily basis for winning team members. In this particular instance, the teacher had arranged reinforcers to be additional worksheets to be worked on by winning team members. As can be noted from the chart, the game playing resulted in an immediate decline in disruptive behaviors through observation periods. During the second week of observation, the teacher removed reinforcers from an immediate daily basis to a weekly basis. As can be noted from the chart, the behaviors continued to decline and appeared to stabilize at a level below that of the immediate reinforcer. During the three-week interval, both morning and afternoon behavior levels appeared to be fairly stable. With the introduction of the game during the morning period in school, both morning and afternoon levels of disruptive behavior decreased; thus, suggesting generalization was most likely maintained by the teacher's ignoring inappropriate behaviors and verbally reinforcing appropriate on-task behaviors.

It must be noted that during the three-week intervention period, two students who were not significantly effected by

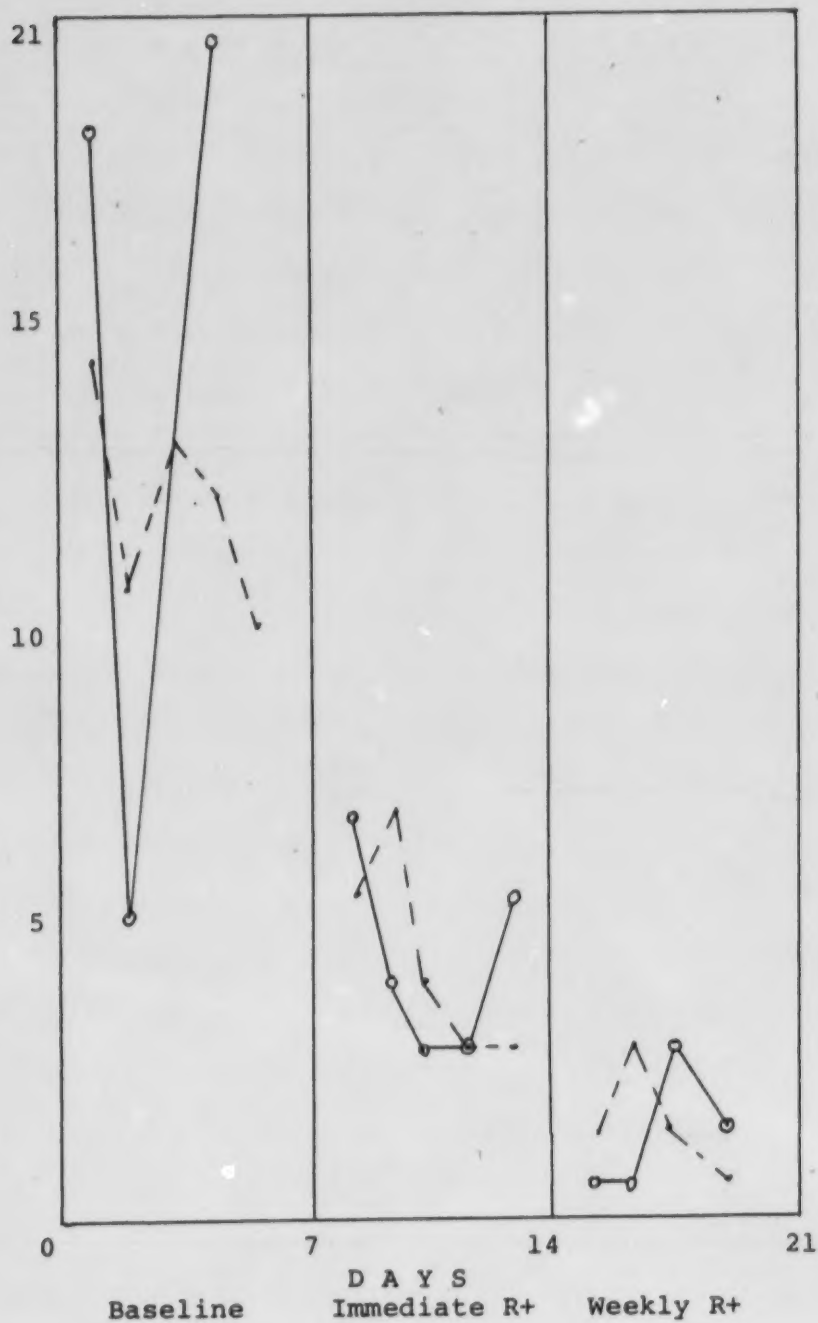
the game were placed on individual contingencies to control disruptive, off-task behaviors.

Discussion

The data suggests that a fairly simple management format can be utilized to control disruptive off-task behaviors in the regular school setting. Such a strategy, employing a game-like format, utilizing peer influence, has tremendous potential in assisting the regular classroom teacher in managing behaviors. The flexibility in tailoring such a program to individual classroom needs is also a positive point in utilizing the game strategy. It is also important to note that while competition between team members is a significant aspect of this program, the program is so designed that a "no lose" situation can develop where all team members can win.

Importantly, this 30-minute per day intervention demonstrates "generalizability" sought by most behavioral programs. It is also interesting that while no data is presented in this report, the first grade teacher noted a significant increase in the amount of work completed successfully by students during game intervals. This increase in academic performance is a welcome spin-off from a program designed primarily to decrease disruptive behaviors. Regardless of group contingency management programs, there seems to be the individual case that will not respond to particular group contingencies. These students must have individual programs tailored to them.

FREQUENCY OF DISRUPTIVE BEHAVIORS DURING TWO
TEN-MINUTE INTERVALS: MORNING AND AFTERNOON



KEY: o—o afternoon off-task
 .---. morning off task

While the study is important as it demonstrates effectiveness, flexibility and, to some extent, the generalization of specific behavior in training; further investigation is needed into the degree of generalizability of on-task behaviors. Follow-up data is needed to assess whether these behavioral changes persisted through time.

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UTILIZING A THOUGHT STOPPING APPROACH
TO TREATMENT IN A FOURTEEN YEAR OLD BOY

Brent Thomson
Arrowhead Area Education Agency
202 First Avenue S.W.
Pocahontas, Iowa 50574

ABSTRACT: Thought stopping has been used effectively for years as a means of treating phobias and irrational thinking patterns. Most of these studies have been concerned with treating adult rather than child clients. This case will illustrate a variation of the thought stopping technique and its application to children and adolescents.

January, 1979

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Introduction:

I am currently interested in researching the usefulness of applying various self-management techniques to various problems encountered in a school psychologist's practice. It has been my experience that the counseling situation is an education or learning process whereby a person learns more adaptive ways of functioning through being taught coping strategies by a psychologist or counselor. Therefore, a school psychologist is a teacher who teaches a client more self-enhancing rather than self-defeating ways of thinking, acting, and behaving. It has been my experience that if a person is taught how to control his thinking and behavior, that this type of counseling process has more benefit to the person in the long run. Dr. David Rimm (1973) is a psychologist who has done much research in the efficient use of the thought stopping exercise. Joseph Wolpe (1958) has also utilized a variation of the thought stopping technique with adults. Arnold Lazarus (1977) also has a book on the market which deals with the usefulness of imaginary techniques with children and adults. I have found this book to be an invaluable resource as it gives the reader many specific techniques which are useful in the counseling situation.

Method:

This student was referred to me because of a parental and school concern. The parents' main complaint was that Jim was no longer interacting well with children his age and was coming home from school and shutting himself in his room for hours at a time. Also, appetite problems and sleep problems were important from the parents' point of view. A behavioral problem identification interview conducted with the parents and Jim indicated that the problems centered around a great number of negative thoughts related to his younger sister's death. Jim had witnessed his sister's death and from checking the

school records, his grades went from straight B's to straight D's within a nine week grading period. Jim told about the tragedy in detail and it was quite evident that this was the major problem of concern presently.

It was noted that shortly after the tragedy Jim's mother noticed the social isolation increasing in frequency and intensity and complaints of stomachaches and headaches began. Jim also related that he had bad dreams that centered around his sister's death. This resulted in him not being able to sleep well. He also started to lose weight through not eating meals with any kind of consistency. In trying to find out what specific antecedent stimuli triggered the inappropriate behavior, it became quite apparent that no one antecedent cue would trigger the behavior.

Results:

The family was asked to cooperate in keeping records of just how often Jim had these negative thoughts. A two week period of time (seven days a week) was used to establish a baseline measurement of the inappropriate thoughts. Jim was taught specifically how to count his negative thoughts through modeling by the author. First, the author verbalized a negative thought out loud and then put a check mark on a 3 by 5 index card. After watching the author do this for three or four times, Jim then had an opportunity to evoke a negative thought out loud and then to record it on the card. This was reinforced socially by the author by such means as smiles, pats on the back, and through verbal means such as "good job", "alright", or "that's right". Once the self-observation and self-counting of the behavior were adequately taught, then the teaching procedure for how to use the thought-stopping technique was introduced. Jim was taught not only how many times a negative thought occurred during the day, but also the direction of that thought. It was found after a two week baseline period that Jim experienced

an average of 10 negative thoughts a day that lasted for approximately 10 minutes each time. It's easy to see from this baseline data that Jim's social and academic functioning would be reduced considerably.

A videotape self-modeling approach was utilized in training Jim how to effectively use the thought stopping technique. A script was set up in which Jim first evoked a negative thought out loud and then counted backwards from 10 to 0 out loud. After reaching zero, Jim then verbally rehearsed a pleasant scene out loud, which was walking along a beach at sunset with his dog. Jim and the author then watched the videotape together and the author gave Jim numerous verbal reinforcements for doing what was expected. After viewing the technique for five times, Jim was then asked to rehearse the script once again. This was done in order to see if Jim understood what was expected and also to give additional positive reinforcement. After this procedure, Jim was then instructed to evoke a negative thought and instead of doing the whole procedure out loud, the practice was accomplished sub-vocally. This procedure was practiced twice.

A daily record of the frequency of negative thoughts was recorded by Jim and also the length of time that they lasted. From the first counseling session to the second counseling session which was scheduled one week apart, the average baseline frequency of 10 negative thoughts reduced to an average of 3 thoughts a day. The average duration data resulted in an average of 10 minutes in baseline to approximately 2 minutes the second week. Between the second and third weeks the average frequency of negative thoughts was 1, as compared with 3 the week before. Also, duration decreased from 2 minutes to 30 seconds. At the fourth counseling session there were no negative thoughts occurring. Jim was asked to reinstitute the thought stopping exercise in case negative thoughts reoccurred. It was decided that a phone conversation would be made in order to follow up with Jim and his parents. In speaking with Jim

and his parents a week later, it was said that there were no negative thoughts all week. Weekly phone contacts were made for the next month and it was found that negative thoughts about Jim's sister's death did not intrude into his thought pattern. A six month follow up indicated that Jim's grades had raised from straight D's to straight B's. Also, Jim was now involved in extra-curricular activities such as dances and he recently had gone out for the track team. His mother reported that the sleeping and eating problems were no longer visible. A one year follow up has recently been made and there continue to be no problems and Jim's parents feel that he has adjusted well and they are quite happy.

Discussion:

This case gives an example of an efficient method of treating fears and irrational thoughts. It is felt that because of childrens' vivid imaginations, they can easily get into this type of exercise. This particular technique has been used by myself on more than one case and has proven to me through the results of it that it is a useable, practical counseling skill to acquire.

I would like to take the opportunity to thank Arrowhead Area Education Agency for its support in the writing of this case study. Arrowhead has given its time and support and it is sincerely appreciated.

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THE HOME-BASED SCHOOL ACHIEVEMENT SYSTEM:
A CASE STUDY

James P. McLallen, Ph.D.
MBAEA9 - SERVICE AREA I
Clinton, Iowa 52732

ABSTRACT: The home-based school achievement system utilizing a behavior rating scale in school in exchange for privileges at home has been shown to be effective in many instances. This article describes a case study using the home-based school achievement system. The intervention data shows a significant decrease in the student's disruptive behaviors. Less disruptive behavior by the student coincided closely with improved grades and teacher behavior ratings on the school report card.

March, 1979

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THE HOME-BASED SCHOOL ACHIEVEMENT SYSTEM:
A CASE STUDY

Introduction

The home-based school achievement system (Schumaker, Hovell and Sherman, 1977a) utilizes a daily report card to provide feedback to parents concerning their youngster's progress in school. The report card usually consists of some method of rating a child during school hours. This rating can be in either behavioral or academic areas, or both. The ratings are sent home and the youngster then exchanges the ratings for some privilege which has been mutually agreed upon by parents and child. A contract outlining the rating system and the privileges is often drawn up to make as clear as possible what is required of teachers, parents and child.

Research has indicated that a home-school report card system can be effective in modifying disruptive behavior or improving academic output (Bailey, Wolf and Phillips, 1970; Harris, Finfrock, Giles, Hart and Tsosie, 1975; Budd and Leibowitz, 1976; Schumaker, Hovell and Sherman, 1977b). The current case study utilizes the concepts of a home-based school achievement system on a modified basis.

Method

The student is an eleven-year old, fifth grade male referred by his teacher for causing some "difficulties" in her class. These include: throwing spitballs; yelling out in class; incomplete assignments; throwing crayons across the room; breaking scissors by throwing the pointed end into the floor; a messy desk; and shooting pieces of an eraser through a straw. At the time of the referral, the student's grades were all Cs, except for one D in penmanship. In addition, his "Habits and Attitudes" ratings on the school report card were all minuses, which indicated that improvement was needed. Despite

his behavior, the fifth grade teacher expressed a genuine interest and liking for the student. She requested some help in reducing his disruptive behavior. This psychologist had previously counseled with the boy on several occasions following a death in the student's family. As a result, the psychologist, the boy and his mother were well acquainted with each other.

The aim of the intervention was to reduce the frequency of disruptive behaviors during school hours.

A behavior contract was drawn up and signed by the student, his teacher and his mother. The contract stated that the student would be rated on a daily basis by his teacher on a scale from 0 - 4 points. The points were allotted on the following basis:

If the student is called down . . . He will earn . . .

5 or more times	0 points
4 times	1 point
3 times	2 points
2 times	3 points
1 or 0 times	4 points

It is recognized that the phrase "called down" is hardly specific when operationalizing undesired behavior. A conference, however, between the student and teacher indicated they had a good knowledge and understanding of what the term means, and that no further definition was needed at that point.

The privilege for which the student is exchanging his points is a trip to see the Chicago Cubs following the end of the school year. During the previous counseling sessions, it was learned that the student is a dedicated baseball fan. When asked what he would work for through improving his behavior he mentioned seeing the Cubs as one of the alternatives. Subsequent consultations with his mother indicated that she would support that concept. The family has relatives in Chicago which would help defray the costs of such a trip.

At the time of initiation, there were approximately 65 school days left

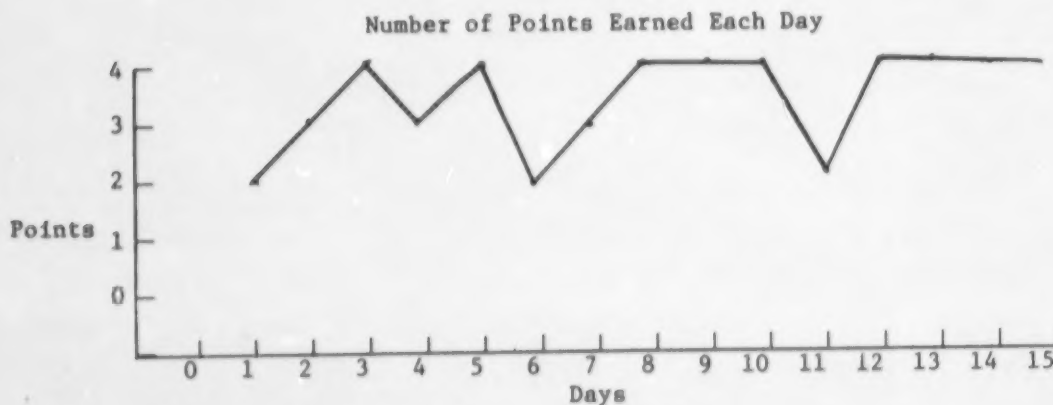
in the year. Rather than require the student to have 4 points every day, which amounted to a total of 260 points, the teacher agreed that if he earned 3 points per day (or was called down twice or less), his behavior would be at an acceptable level. The total needed then, was an average of 3 points per day, or 195. This was rounded up to 200 points as an easier number for the student to keep in mind. The number of points earned was kept both at home and at school. At the end of each day at school the student charts the number of points he earned for that day.

In summary, the student's behavior is being rated on a scale from 0 - 4 every day. His goal is to earn 200 points by the end of the school year. This requires an average of slightly over 3 points per day. If he earns 200 or more points, his privilege is to pick the Chicago Cubs baseball game he wants to see.

Results

No baseline data was obtained prior to intervention. His teacher, however, reports that she had to make reference to his disruptive behavior an average of 5 times per day. Although that is not a data based figure, it can be used as a good estimate of baseline. At the time of this writing the student has completed 3 full weeks, or 15 school days, utilizing the intervention plan. As can be seen from Table I,

Table 1



the number of daily points increased suddenly and dramatically. Put another way, the student's disruptive behaviors have decreased from an average of 5 per day, to an average of 1 per day. This represents an 80 percent drop in disruptive behavior for the 3-week period.

There were secondary effects as a result of the student's improved behavior. The end of the third school quarter coincided with the end of the third week of intervention. Thus, any changes in the student behaviorally and academically could be evidenced on the school report card. Table 2, presents data from his "Habits and Attitudes" section of the school system report card. An (S) indicates that the habit is satisfactory. A minus (-) sign indicates improvement is needed. A plus (+) sign indicates that satisfactory improvement is being made. Clearly his behavior rating on the school report card reflects his improved behavior.

Table 2

Comparison of Second and Third Quarter Behavior Ratings
from School Report Card

<u>Social Habits and Attitudes</u>	<u>Second</u>	<u>Third</u>
1. Works and plays well with other children	-	+
2. Respects rules of school	-	S
3. Is courteous in manner and speech	-	S
4. Accepts responsibility	-	S
<u>Work Habits</u>		
1. Follows directions	-	S
2. Is careful with books and materials	-	S
3. Is neat and orderly in his work	-	-
4. Makes good use of time	-	+

An unexpected yet gratifying result is presented in Table 3. Not only did his behavior ratings improve significantly, but his letter grades in all his academic work improved at least a full letter, with the exception of penmanship.

Table 3

Comparison of Grades Between Second and Third Quarters

<u>Subject</u>	<u>Grade</u>	
	<u>Second Quarter</u>	<u>Third Quarter</u>
Reading	C	B
English	C	B
Spelling	C	A
Penmanship	D	D
Arithmetic	C	B
Safety and Health	C	B
Science	C	B
Social Studies	C	B

Discussion

It is clear that this student has significantly improved his behavior in school, with the additional result that he has improved his academic grades. The whole purpose of any behavioral intervention, in the psychologist's opinion, is to provide a structure by which a student (or anyone) can experience success. The ultimate goal is not to make the student's data look good, but rather to allow the student to begin experiencing some intrinsic reinforcers which success allows. Ideally, these intrinsic reinforcers then become the primary reinforcers and the structure which allowed for their introduction can thus be removed.

Data does, however, give important information from which inferences can be made as to the efficacy of an intervention. One inference is that this youngster is willing to curb his disruptive behavior in order to see the Chicago Cubs. Neither the behavior contract nor anything concerned with this intervention mentioned improving this student's grades. Yet in all but one area

(penmanship), his grades improved at least a full letter. It is inferred that this student is beginning to experience some of those intrinsic reinforcers in addition to the external one of viewing a Cubs baseball game. (Indeed, it could be strongly argued that any true Cubs fan must have the capacity to experience intrinsic reinforcers!)

Several factors came together in this case which seemed to point this student toward the changes he has thus far exhibited. First, he has a teacher who cares enough about the student to institute an intervention program to improve his behavior. Second, the student was allowed to come up with his list of reinforcers, not one that an adult thought he should have. From that list a reinforcer was selected which was mutually acceptable to both parent and child. Third, he has a parent who is flexible enough to go along with the student's reinforcer. Fourth, the psychologist had previously established a good relationship with both the student and the parent, which facilitated the entire process. The psychologist continues to make weekly visits to provide support for the student's progress, and to help make adjustments where necessary. For example, this student thus far, has a pattern of exhibiting more disruptive behaviors on Monday than on any other day during the school week (days 1, 6 and 11, on Table 1). He has earned 2 points on each of those Mondays. Two points is below the average per day he needs to reach his goal at the end of the school year. Thus, he has started his school week "in the red", and must make up for that low score during the rest of the week. It was suggested to him to work extra hard on Mondays to eliminate disruptive behavior so he can start the week at least "even".

Finally, the behavior contract, which was agreed upon and signed by the pertinent parties, spells out very clearly what is required of each

participant. If any question arises, this agreement can help resolve it.

The psychologist plans to obtain baseline data on future interventions of this type. This will provide hard data as opposed to teacher reports to evaluate the effectiveness of such an intervention.

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DIAGNOSIS OF NEUROLOGICALLY BASED HYPERACTIVITY CONTRAINDICATED

Wallace E. Gould
Arrowhead Area Education Agency
Greene County Courthouse
Jefferson, Iowa

Abstract

A child, previously diagnosed as neurologically hyperactive and treated with Ritalin for four years, is reevaluated. Evaluation results do not support previous diagnosis. An environmentally based deficit in impulse control is indicated and treated.

January 1979

DIAGNOSIS OF NEUROLOGICALLY BASED HYPERACTIVITY CONTRAINDICATED

Introduction

Ritalin is contraindicated for use in a nonneurologically based impulse control deficit as addictive and habituating. Treatment of choice would be family and individual counseling.¹

Method

This student is a caucasian female ten years of age. All areas of previous and present measurement (ages 6-9 and 9-1 respectively) with the exception of social/emotional, show average or above performance and somewhat higher potentials.

Surface evaluation through the house-tree-person technique of emotionality and personality factors indicate that this student's problem appears to be one of moderate anxiety, insecurity, helplessness, and a strong unsatisfied desire to obtain environmental satisfaction. The dominant theme tying this surface evaluation together is that of a lonely, drifting child needing friends but not knowing how to get them and with a strong desire for self and situational control. There was no evidence through this technique to support a diagnosis of neurological hyperactivity. Rather the obverse was true. There was no fine motor tremor. Attention was quite good and there was no tendency to impulsivity. There was much detailing of high quality.

Evaluation through the Rorschach technique supports previous intellectual, academic, emotional, and personality analysis. A high level of mental capacity exists although efficiency is somewhat reduced through self and situational

¹Drs. Berryhill and Hizon, 1977 Inservice at Iowa Central Community College on drug therapy.

overcontrol. The student appears to be stimulated by the environment but responds by overcontrolling her reactions. She appears to be disturbed by acute emotional stimuli and may not be able to maintain her excessive control at these times. At these times she may exhibit behavior unusual to the situation. She does not appear to have had enough proper reality based experience to provide a base to support her intellectual capacity, especially in the social/emotional sphere. She depends more on her own interior mental activity than outside stimuli to operate on, and this may not be sufficient at times to provide enough reality based information to perform satisfactorily. There was no evidence to support neurological hyperactivity. Rather the obverse was true. She was well organized and was overcontrolled rather than uncontrolled. She was quick and accurate on all but the color cards which required substantially more time, up to 31 seconds for a response, again indicating an emotional difficulty rather than a neurological deficit.

The Bender was used to find evidence of neurological dysfunction in the form of tremor; poor attention; poor form; and impulsive, quick drawings. The results evidenced good control; no tremor; excellent attention; and no impulsivity or quickness of execution. Approximately five and one half minutes were spent on the drawings with two minor errors of integration, well within the limits for a nine year old girl.

The WISC-R was used to provide an intellectual assessment and to check for neurological deficits through the performance tests. The Performance Scale was ten points higher than the Verbal Scale which is the obverse of what would be expected in a child suspected of having a neurologically based deficit in impulse control.

Previous psychological evaluation at the age of six years nine months specifically stated findings of good attention, good control, and no impulsivity.

Previous home counseling through the AEA social work supervisor indicated an environmental difficulty involving the mother and daughter and older sister supporting present and previous evaluation results indicating an environmentally based problem in impulse control.

A diagnostic interview with the child's mother indicated a problem involving the use of the child as a scapegoat by the mother and older sister and overcontrol of the child's freedom by the mother and older sister which was extant for a long period.

Benefits of psychological intervention were to be a correct diagnosis of the problem followed by proper treatment. Specific goals were to provide a release from anxiety in dealing with situations where she had little positive experience; reduce behavior oriented toward controlling herself and the environment; developing a positive experience base to work from in social/emotional situations; and elimination of drug therapy.

Specific treatment strategies utilized were individual counseling at school through an AEA female psychologist to provide a positive female authority figure experience; a coordinated home intervention counseling program through the AEA school social worker to specifically change the mother/older sister/student relationship; elimination of Ritalin treatment through the psychiatrist; LEA resource center placement to work on verbalizing problems that are bothering her, improve concentration on her work versus controlling herself and the environment, and developing techniques in self-control. Duration of individual counseling and family intervention would be one academic semester. Resource center assistance would follow for approximately one year.

Results

Results after discontinuance of Ritalin for one year show no signs of

impulsivity of a neurological base. Rather, the child seems calmer and more relaxed.

Individual and family therapy results after one year show a slow but steady improvement in social deportment at home and school as reported through the school nurse, resource and regular classroom teachers, and mother.

Discussion

The implications of this case involve the use of drug therapy as a panacea for instant results. Obviously, drugs can cause almost instant results. But the use of drugs to control without solving the problem result in a possible delay in eventual remediation. The drugs merely cover up the problem which will possibly surface later and there are always side effects to consider. Even a sure diagnosis indicating drug therapy should in most instances be preceeded by other attempts to solve the problem.

ENCOPRESIS: TREATMENT IN A SCHOOL SETTING

Stephen D. Bates, Ed.D.
Area Education Agency 12
315 1st Avenue S.W.
Le Mars, Iowa 51031

Abstract:

By means of counseling with a student and her parents, as well as utilizing a retraining schedule, a persistent case of encopresis was successfully treated.

February, 1979

ENCOPRESIS: TREATMENT IN A SCHOOL SETTING

Introduction

"Encopresis is a symptom marked by fecal soiling past the time that bowel control is physiologically possible, and after toilet training should have been accomplished..." (Freedman et. al., 1976, p. 2123).

J. R. Bemporad summarizes, "Many families with encopretic children demonstrate a peculiar type of pattern which reinforces the prolongation of soiling for psychological motives" (Wolman et. al. 1978, pp. 177-178). He further states that "In older children, individual therapy, in addition to work with parents, may be necessary to alter personality problems of the child as well as to allow him to learn more appropriate modes of communicating anger and disappointment" (Wolman et. al., 1978, pp. 177-178).

Method

A. The student referred to in this case study is a ten-year-old third grader who is functioning within nearly normal limits academically. Personality instruments indicate that the child has a very low self-concept, is concerned about her mom and dad and is suffering from sibling rivalry. She is a youngster with strong dependency needs and desires to be well accepted both at school and at home. She feels that she cries too easily and gets "nervous" because she worries about many things. The child seems to be a rather "thin-skinned" type of person.

The student comes from a family with three other siblings, and they live together with their mother and father. The father works as a hired farm hand and has just recently received a very serious injury in a truck mishap.

The mother works part time as a waitress.

Due to her father's employment, the youngster described in this case has been in seven different schools within her first three years of schooling. She is the oldest child in the family, and is given many responsibilities at home. Two of the siblings in the family have problems which demand a great amount of the parents' time: one child is visually impaired, and the other has chronic hearing problems.

B. The child was referred for psychological intervention because she was soiling herself in school. This behavior presented numerous problems. Other children in school made fun of her, and avoided her due to the odor she emitted. She was for all practical purposes a "loner". The school had difficulty getting changes of clothing for her as well.

In reviewing the youngster's cumulative file, and in talking with her mother, it was discovered that the problems of encopresis had been with the child for roughly three years. There had been no attempts at treatment for this problem in the past.

C. The goal of the psychological intervention strategy was to see if conditioning and therapy could be used to effect a change from daily soiling to proper daily toilet habits.

D. Baseline data was gathered over a two week period of time, both at school and at home. This data indicated that the child was soiling herself on a daily basis.

The strategies involved in treatment included encouraging the mother to take the child to a physician for a check to see if the youngster was constipated and experiencing impacted bowels. Since the child had complained at one

time of painful bowel movement, this was thought to be a necessary step. The physician indicated that he felt the youngster was not constipated, and that the treatment should be psychological rather than medical.

A conference was held with the child's mother and father to discuss the family's problems. The conference lasted for about two hours, and during that time the conversation centered around: child rearing practices in general; the use of positive reinforcement and communication skills in particular. Much soul searching was done by the parents in terms of their treatment of the youngster in the home, and of applying punitive disciplinary measures to her. The parents felt that perhaps they were giving their daughter extensive and overwhelming responsibilities because she was the oldest child.

Upon conclusion of the conference, it was felt that both parents seemed to have a good grasp of their daughter's problems and were desirous of wanting to help her get better by trying to understand her better and by giving her love and affection.

The retraining phase of the treatment program consisted of the child being required to sit on the toilet at school four scheduled times during the school day. She did not object to this type of procedure nor did it cause her any embarrassment with her peer group. The youngster seemed to accept this retraining as a matter of "getting better". The classroom teacher and school nurse monitored this program on a daily basis. The retraining process also went on at home with the mother making the child pay attention to her toilet habits on a regular basis. Positive verbal reinforcers were used at home and at school to encourage the child.

The psychologist called the mother twice during the first week of this

treatment and once a week thereafter to talk about how things were going and to give advice and encouragement. The psychologist also monitored the child's retraining progress in school on a twice a week basis for the first month.

Results

The results of this treatment were quite satisfying for the child, and her family as well as the school. After the treatment was initiated, in terms of toilet retraining and positive reinforcements, with good communication skills being practiced at home, the child did well in making sure that she made it to the toilet on time. In school, the four times a day regular trips to the bathroom paid off as the youngster started to defecate during these times. The child felt very good about her ability to change her behavior. The child also counseled with this psychologist on a once a week basis for five weeks. It should be noted that in two calendar months, the child had no soiling accidents at school or at home.

Needless to say, the child's family is quite happy with her progress, and seem to have a genuine grasp of how they can better relate to her.

The child is becoming more readily accepted by her schoolmates and her overall level of self-confidence is much improved. She appears to be much happier at school and at home.

Discussion

It is felt that this case study is one example of how School Psychologists can be effect change agents through their involvement with children, families, and schools.

The treatment in this particular case was made considerably easier by having an understanding school system, particularly the teacher and school nurse, as well as an understanding family who responded positively to suggestions given in the conferencing setting. It was also easier because the home monitoring process or follow-up could be done via the telephone.

The overall treatment of this child was successful because of the fact that several significant adults in the child's life appeared to want to work through and help the child correct her problem. The child herself also desired to change her inappropriate behavior.

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A SUCCESSFUL INTERVENTION
IN THE CASE OF A
SCHOOL PHOBIC THIRTEEN YEAR OLD BOY

Doris A. Lohry
Area Education Agency 12
1520 Morningside Avenue
Sioux City, Iowa 51106

ABSTRACT: A thirteen year old seventh grade boy had been absent for twenty-four days because of phobia about returning to school. Successful intervention consisted of establishing a "yes" set and temporarily breaking his routine.

March 28, 1979

INTRODUCTION

School phobia, or school refusal, is a relatively common occurrence, happening most often in younger children from kindergarten through fourth grade. It is one of the few psychological disorders during the school ages for which boys do not outnumber girls, the frequency being about equal (Papalia, 1975). In elementary school children, the school refusal is frequently attributed to separation anxiety, but school phobia frequently does not develop until after the child has attended school for several years. Therefore, it seems more likely that threatening or stressful incidents have occurred at school and the child feels much more protected at home (Kauffman, 1977). However, in Lange's Handbook of Psychiatry, 3rd Edition (Solomon and Patch, 1974) school refusal that has its onset in adolescence is much more serious, and can involve severe, pervasive anxiety. As with the younger children, the syndrome seems to manifest a need for close mothering, but it also is a dimension of fearfulness of social contact and apprehension about environmental change.

In studying school phobics, differentiation must be made between those who are really made quite ill from their anxieties and truants who seldom insist on staying home, but usually start out for school and then just never arrive. School refusers usually are genuinely uncomfortable enough that their indulgent mothers send them to bed, while those that are malingering complain of illness but are rarely able to perform a convincing portrayal (Solomon and Patch, 1974; Papalia and Olds, 1975).

The symptoms that school phobic children exhibit typically include complaints about abdominal pain, nausea, headache, and other physical symptoms that seem to disappear as the day goes on, if the child stays home; they seem to be much more frequent on Mondays (Kauffman, 1977; Papalia and Olds, 1975). The child frequently has trouble verbalizing his or her all-pervading anxiety, but reassurance by adults that everything will be all right once he gets to school rarely helps.

Remediation for very young children, those in kindergarten through second grade, is simpler than for older children. It is vital to get the child back to school as soon as possible, ignoring tears, temper tantrums, protestations, and returning the child promptly if it does turn up at home during the day. Blackham and Silberman (1975) report a step-by-step method for dealing with the school phobic child. First, early referral is important. The phobic child should be referred on at least the second or third day of the problem. Second, the somatic complaints should be handled casually. Third, the child is forced to go to school and stay there, usually being delivered by the father rather than the mother. Fourth, a structured interview with the parents is held and they are given instructions to follow. They are not to discuss school attendance with the child, are to be firm, and are to compliment him for overcoming his fears and staying in school. The fifth step is counseling with the child after he is in school for a few hours, and then lastly, the sixth step is a follow-up phone interview with the parents to gather data and to find methods of preventing further school phobic outbreaks. In more deep-seated cases of school phobia, how-

ever, more complicated intervention methods, such as psycho-therapy for the child and family counseling, may be necessary, so that problems affecting the whole family unit may be resolved.

Although the thirteen year old boy presented in the following case study seemed, at first, to have a serious phobia, the warm support given him by his family at home and his good relationship with his peers and teachers at school were positive aspects of his environment which enabled him to overcome his fears after a relatively simple intervention.

METHOD

Tony was referred by his school principal because he had missed school for the entire month of January, coming only the first day after Christmas vacation. Neither the social worker nor the principal seemed to be able to persuade him to return, so the psychologist was asked to assist. When the social worker saw Tony and his family, the week before, he felt that Tony was seriously withdrawn. Tony had come into school the day before the psychologist was asked to help with the problem, and had managed to come in and talk to the principal, but felt too anxious or ill to stay, so left and returned home. The principal reported that he knew of no problems at school that would have caused Tony to feel unwelcome, and also reported that Tony had fairly good grades, so he felt that scholastic stresses were probably not the cause of Tony's reluctance to return. The principal did report, however, that Tony had had a history of staying away from school around that time of year, but that according to his grade school principal, the

absence had never been that long.

Since Tony could not make himself come to school, this psychologist drove to his farm home the morning after the referral was made. The setting was neat and cheerful, and both parents expressed great concern over Tony's apparent inability to force himself to return to school. Tony's father reported that he had feelings of empathy for Tony's anxiety reactions, because about five years ago he had gone through a similarly severe period of physical and emotional stress. It occurred when he had first contracted to buy the farm, and financial pressures plus pressures of getting the crops in in the spring were extremely great. He became so weak out in the field that he was unable to walk and had to sit down on the ground for several hours before he could return to the farmhouse. He was on tranquilizers for a good deal of that period, and then "just decided that he was not going to let things bother him that much". He quit the tranquilizers, and although pressures still exist, he reports that he is able to cope with them without resorting to the chemical tranquilizers. Tony's mother is on a very low dosage of tranquilizer at this time, she reports, and has been taking them for a number of years.

Tony is a slender, almost aesthetic-looking teenager, with dark brown eyes and short, dark hair. He is the youngest in the family, having two older sisters that are out of school. His father and mother reported that the family was a very close-knit one, and that loud arguments never occurred. Problems were talked out, and direct confrontation was assiduously

avoided. The parents do not drink or smoke. A number of relatives live close by, so a great deal of socialization occurs between the families, who appear to have compatible interests and affection for one another. Tony's grandmother lives in the same town where the school is, so when he feels ill or needs anything he is in the habit of calling or going over there. His older sister, who works in the bank in town, drives him to school in the morning, and he takes the bus home at night. The sisters and the grandmother are also greatly concerned about Tony's apparent inability to return to school, according to his parents.

When asked if Tony was having trouble relating to his peers, the parents replied that he had a large number of good friends who were anxious to see him return. He got good grades, was on the basketball team, and his school refusal seemed all the more puzzling to them because of the lack of any apparent problems that might have precipitated it. While he was home, he was keeping up with his classes somewhat by reading and studying.

Tony has had trouble with sinus infections for many years, according to his parents, and the reason he stayed home in January was because of a rather severe one that required the use of antibiotics and decongestants. He was apparently quite ill for at least one week, but after the sinus infection symptoms had gone, he still complained of dizziness and of stomach upset. He seemed unable to function, and was weak and withdrawn. His mother was quite solicitous of this, her youngest child and only boy, and protectively kept him home rather than precipitate another unknown, and

possibly serious, situation. Tony's father, who had experienced the same sensations when he was dealing with the stress of buying the farm five years before, was sympathetic and seemed to realize the intensity of Tony's feelings.

The social worker had seen Tony and his family twice, apparently when the crisis was at its peak. The social worker reported that Tony seemed withdrawn, almost to the point of pathology, and he felt that if Tony chose to continue to confront stress with withdrawal, situations could become much more serious as he becomes older.

At the point this psychologist visited Tony and his family, it had been almost a month since he had been at school. His sinus infection was cleared up, and Tony appeared quiet but self-possessed. Because the Bender VGMT is a relatively structured exercise, but will frequently show disturbances of aggression or anxiety, it was administered to Tony. He made a perfect rendition that was firm and without apparent psychological ramifications of either withdrawal or aggression. At this point, on this sunny, cold January morning, this psychologist hypothesized that, at least in this case, there seemed to be very little pathology involved, but rather over-concern by the parents and inability by Tony to make up his mind to leave the warm comfort of the home. It was explained to Tony and his parents that his symptoms constituted as much of a problem as any pathological disease, and that the physical distress he felt was real. However, it was also explained that the longer Tony put off coping with this distress, the

more difficult the solution would be. It was further explained that there is a great deal of literature on the subject, and that the consensus of most authors is that the solution to school phobia is to return to school as soon as possible. This psychologist suggested to Tony that he go get his things, since she had to return to Tony's school for some business. Within minutes they were on their way, and during the drive the conversation was kept along here-and now types of facts, such as what subjects Tony liked and whether he would be able to play in the ball game next Monday.

At school, Tony and the psychologist went to all Tony's classes to get makeup assignments, and he was greeted with enthusiasm by his classmates. The following Monday, the psychologist also picked up Tony at his home and brought him to school for further testing. The reason for this was twofold; to break the syndrome of Tony's being driven to school by his sympathetic sister, and to provide an opportunity to this psychologist to reinforce Tony by praising him for his coping with this stressful situation successfully.

The WISC-R was administered to Tony to ascertain whether there were any implications from his intellectual attainments for his past school phobia, and also because clinical manifestations of anxiety can frequently be gleaned from depression of some subtest scores and from verbal replies to others. Tony was extremely slow to answer questions, but when he did reply, his answers were well thought out. He appeared to the examiner to be a good thinker and did not seem to be nervous during the testing, only very

quiet and reserved. He achieved a Performance I.Q. of 124, a Verbal I.Q. of 111, and a Full Scale I.Q. of 119. His Digit Span subtest was significantly high, and showed that he has an excellent number memory. This subtest is also subject to anxiety and a low score can indicate that the person cannot concentrate because of other pervading thoughts. Thus, whatever Tony's mental state had been earlier, it apparently was back to normal at the time of this testing session. Tony's Performance scores were all above average, and his ability to see both abstract and concrete spatial relationships was significantly high. These subtest scores suggest that he has excellent visual-motor coordination and an ability to synthesize parts into wholes. This particular combination of skills suggests such careers as engineering or architecture. The excellent Bender reproduction mentioned earlier also confirms his ability to visualize spatial relationships and the absence of significant anxiety.

RESULTS

At this time, Tony is still in school and functioning very well, according to school authorities. A number of steps have been decided and agreed upon by Tony and his family for management of future absences caused by illness. For instance, it has been discussed between the psychologist, the family, and Tony that when he is free of fever for one or two days, he will automatically return to school. If he feels faint after getting to school, he may retire to the nurse's office or another private

area where he may rest with his head down until the feeling passes. However, it has been agreed upon that he will not call home or call his grandmother to be picked up, but will realize that he is going to stay and cope with the anxiety feelings and the weakness at least until the end of the school day and the bus comes. However, he is encouraged to return to his classes as soon as possible, no questions asked, as soon as the feeling of anxiety or faintness passes. He has been praised by this psychologist for returning to school, and has been assured that he is able to cope and will be able to cope more effectively as he practices the technique of actively confronting and overcoming his anxieties rather than withdrawing from them. If Tony does call home, the parents should act solicitous but remind Tony that the agreement was that he should stay in school, and praise him for making the difficult effort to do so. The principal, too, should follow the same procedure, letting Tony have "time out" but immediately praising him when he returns to the classroom.

It is possible that the combined stress of moving from grade school to the high school and seventh grade, the sinus infection, the severe winter weather, and the parent's concern all combined to produce the lengthy reaction and absence. It is hypothesized by this psychologist that if parameters are established for attendance, and these are clear-cut and agreed upon by Tony and his parents, as a helping, not punitive, type of solution, that the problem will probably not occur again. After any absence of more than three days, however, consultation between the parents and the principal about Tony's health and intervention by the

principal, the social worker, or the psychologist before the problem becomes too entrenched should be the established procedure.

DISCUSSION

Although many factors seemed to point to severe pathology in Tony's school withdrawal, fortunately there were strengths available to him to counteract the negative effects. Tony's father's emotional problems of five years before may have influenced Tony, although unconsciously, to follow the method of coping with stress by withdrawal. However, Tony also has a good role model to follow in his father's successfully learning to cope with the stress and learning to do so without the aid of tranquilizing drugs. In other words, he has within his own family a role model to emulate and proof that one can learn to deal successfully with life's problems.

It is hypothesized by this psychologist that the intervention was successful because of a number of factors. Time was one of them; Tony's original morning weakness had passed, since the time for departing for school was long since gone by the time this psychologist had arrived and visited with the family. Keeping the behavior in the present and not dwelling on the dynamics of why Tony found returning to school so stressful was probably another. This psychologist's not allowing any opportunity of discussion of "whether" or "when" Tony was returning to school but rather matter-of-factly assuming compliance made it very difficult for

Tony to refuse because such a strong "yes" set was set up that it was almost impossible for him to buck the tide. A third was the element of breaking the habit sequence of riding to school with his sister at a certain time each day; the departure that first day with the psychologist, who was someone Tony had just met, at midmorning in a warm and different car and being picked up the following Monday morning by her probably helped break the distress-avoidance pattern that had existed previously.

In summary, in dealing with school phobia in teenagers, the first priority is to break the avoidance pattern and get them back to school. The teenager should then be helped with methods of coping with the physical distress; practical demonstrations should be designed to show that fainting almost never happens, and that slow, deep breaths rather than hyperventilating will relieve the panic feelings. Discovery of and alleviating as much as possible any precipitating feelings of worry about the relationship the teenager has with certain peers or teachers should be done by the psychologist, and the teenager needs to be shown that he is capable of coping and facing most situations.

Follow-up is essential, and parents need to be encouraged to arrange with their teenager an agreed-upon set of parameters which will be unquestionably followed in regard to degree of sickness and school attendance. Emphasis should be on helping the teenager help himself form positive patterns of coping with reality.

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REDUCING THE INAPPROPRIATE
VERBALIZATIONS AND AGGRESSIVE BEHAVIORS
OF A TRAINABLE RETARDED-AUTISTIC MALE

Thomas R. Brock - Psychologist
Jill Philipp - Teacher
Mississippi Bend Area Education Agency(9)
Service Area I

Clinton, Iowa

ABSTRACT:

This case study describes the procedures utilized in decreasing the inappropriate verbalizations and aggressive behavior of an eleven year old boy whose primary handicapping condition is trainable mentally retarded and who has also been described as possessing autistic-like characteristics.

MARCH, 1979

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INTRODUCTION

In the past various techniques have been employed to treat subjects with autistic-like characteristics. Behavior management procedures appear to have been more successful in changing behavior, especially when compared to more traditional psychiatric methods. This case study describes the behavior management procedures and the adjustments made in the procedures over six months time through the consultation process between the authors.

METHOD

Background

Jim (a fictitious name) is an eleven year old boy who is placed in a program for the trainable mentally retarded. Past intellectual evaluations indicate that Jim is functioning in the moderate range of retardation. Reviewing his school files reveals a considerable number of stereotypic behaviors. In May of 1978 a conference was held which involved Jim's teachers, the principal, the psychologist serving the program, and Jim's mother. At that time a decision was made for him to be evaluated at the Autism Clinic at the University of Iowa during the summer. The diagnosis from the Autism Clinic is that Jim's primary disability is retardation with a secondary disability of autism.

Jim's behavior during school years has generally been very disruptive to himself and others. At the time of referral to the Autism Clinic Jim's behavior problems included loud laughing, loud talking out in class, making loud noises with his hands by clapping, aggressiveness, inappropriate verbalizations (swearing), poorly controlled responses to noises such as fire sirens, and poor interactions with peers. He was described as having very little interest in interacting with other students and showed

no signs of "warmth" or physically approaching others. Jim's spontaneous speech was mostly irrelevant talk (e.g. Jim might hold up a book with a picture of something and ask "Is that you?"). He also was described as possessing hand flapping and hand wringing behavior.

Intervention Plan

In a conference involving the staff of the Autism Clinic and the two authors it was decided because of the large number of problem behaviors that a prioritization of those behaviors which were of most concern with respect to Jim's functioning, should be selected to begin a behavior change program.

Two behaviors were selected for the behavior program: 1) Inappropriate verbalizations and 2) Aggressive behavior. More specifically, inappropriate verbalizations were defined as a list of words or phrases which Jim emitted orally. Most of the words would fall under the general category of swearing. During the intervention five new words/phrases were added to the list. Aggressive behavior was initially defined as swinging an arm and hand at someone whether the individual was struck or not.

Baseline data was collected on both of these behaviors. A frequency count was done daily by the second author and her teacher associate for the eight days and reported in GRAPH I and GRAPH II respectively.

The intervention plan for the two behaviors differed. For the inappropriate verbalizations a response cost system was employed in an attempt to decrease this behavior. Each hour of the day Jim would receive ten picture cards of trucks and cars. Each card represented one minute of free time which Jim could have at the end of each hour if he still possessed the

card. One card would be removed for every emittance of a word/phrase from his list of inappropriate verbalizations. Every morning upon entering the classroom Jim would go over the rules of the system and list of words/phrases with the second author. The reason picture cards of trucks and cars were used was that Jim spent most of his free time drawing or playing with toy trucks and cars. After six weeks of intervention and three weeks of very low frequency emittance of inappropriate verbalizations, the response cost was increased from one minute of free time to three minutes of free time. After nine weeks of the program and six weeks of very low frequency another change in the intervention was made. A verbal substitution process was begun. When Jim's verbalizations approached inappropriateness or were inappropriate, a substitute verbalization was given to him and he was requested to practice it. The purpose of the first adjustment of the response cost strategy was an attempt to completely extinguish even the very low frequency of inappropriate verbalizations. The second adjustment was viewed as necessary because of Jim's limited ways to express himself verbally. These two adjustments are noted in GRAPH I.

The second intervention for the aggressive behavior was begun coincidentally with the above intervention. Again the intervention was an attempt to decrease the behavior. When Jim exhibited an aggressive behavior toward staff or peer the second author would yell a loud "no", if possible grab his arm, and then implement a "cornering" procedure. In "cornering" Jim the second author or teacher associate would escort him to a corner where he was required to remain until he was quiet and physically calm for 45 seconds. When Jim was uncooperative during the cornering

procedure a physically restraining hold was applied to him. His arms would be held and crossed in front of him by a staff member standing behind him. When Jim had calmed this restraining hold was discontinued. Other "aggressive" behaviors began to appear as the hand and arm swinging decreased. The same procedure was applied to these behaviors as they appeared and are noted in GRAPH II.

RESULTS

GRAPHS I and II show the baseline data, intervention data, and changes for the interventions. The graphs both indicate a significant decrease in Jim's inappropriate verbalizations and aggressive behavior.

Other than the obvious changes which the graphs point out, there appears to be considerable positive side effects. Jim seems to be much more interested in approaching others in a physically appropriate way. His "academic" and pre-vocational work output has improved significantly, according to the staff. Although his loud laughing, irrelevant verbalizations, and hand flapping have not decreased to any significant degree, he appears to be interested in developing relationships with both peers and staff. After about eight weeks of the intervention for aggressive behavior, Jim began to corner himself, thus indicating some responsibility for his own behavior. In going through the list of words/phrases and rules each morning, Jim began to add inappropriate verbalizations on his own and has not used the new words/phrases at school to the date of this paper. Finally, because of the verbal substitution process, Jim is beginning to be able to greet people appropriately.

DISCUSSION

This program apparently has been very effective with Jim to this point

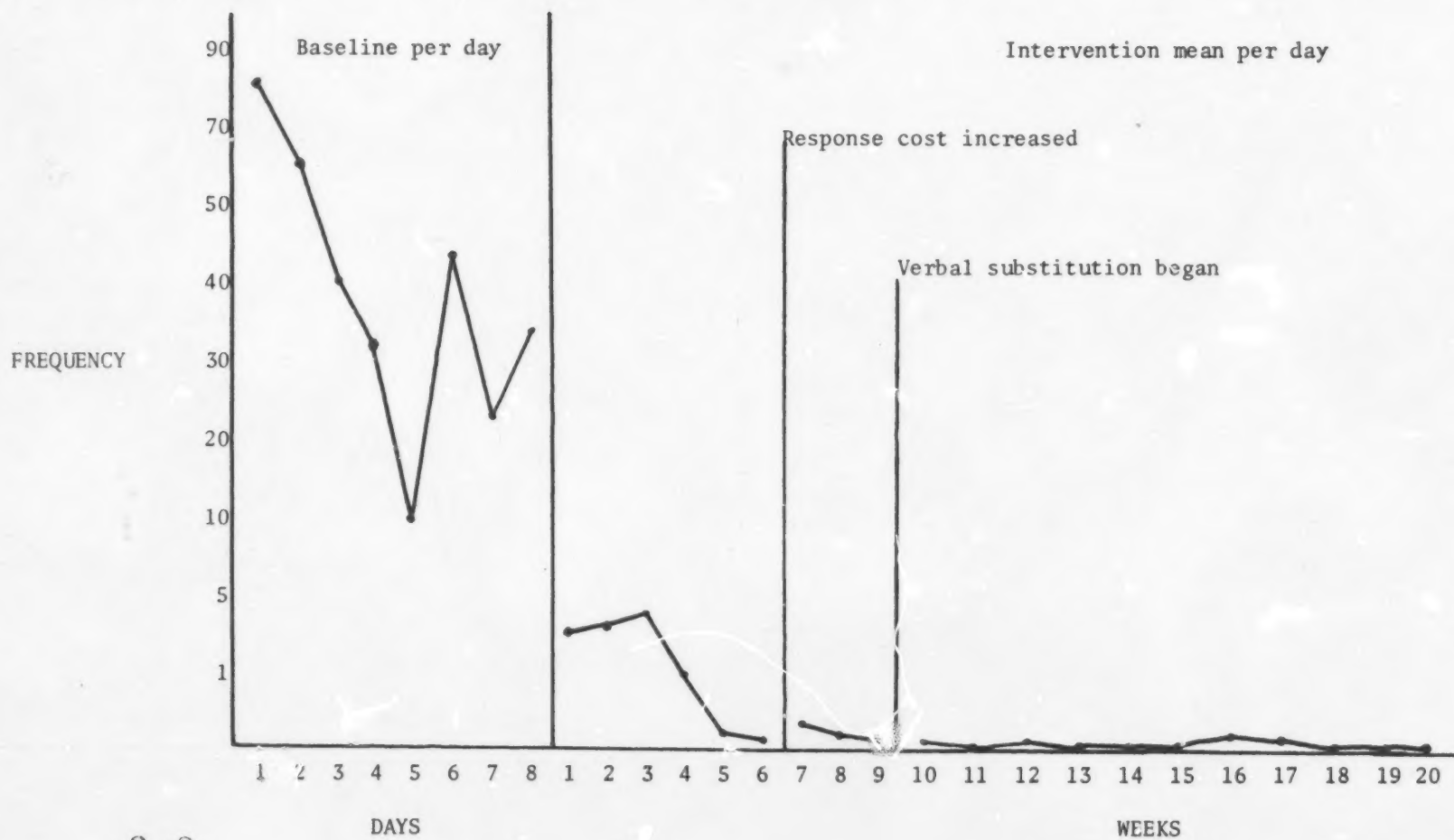
in time. The cooperativeness in the consultation process of the staff involved with Jim played a major component in the success of the behavior program. In addition to the intervention, it is the first author's opinion that the success of the program is due in large part to the consistency with which the second author and her teacher associate have carried out the procedures outlined above. Also of import to the success of the program is the positive nature of the interaction between the staff working with Jim, and Jim himself. Although the interventions have a negative or aversive "flavor" to them, the staff carried them through without showing anger or distress, and at the same time demonstrated to Jim how positive they felt when he was not engaging in the target behaviors and/or was acting appropriately.

One danger in utilizing this program is the possibility that during the cornering procedure the student may become quite aggressive. Therefore, anyone desiring to implement such an intervention should be both willing to be physically involved and be aware of techniques on how to physically restrain others.

In this program the authors should have been aware that symptom substitution was going to occur because of Jim's limited way to interact with his environment. Therefore, in hindsight it would have been very appropriate to plan and implement systematically a program for increasing Jim's interaction skills, which would have run coincidentally with the other interventions. Regretfully, the authors did not interject this approach until the ninth week of the program, and also did not concretely measure the change that occurred from the approach.

GRAPH I

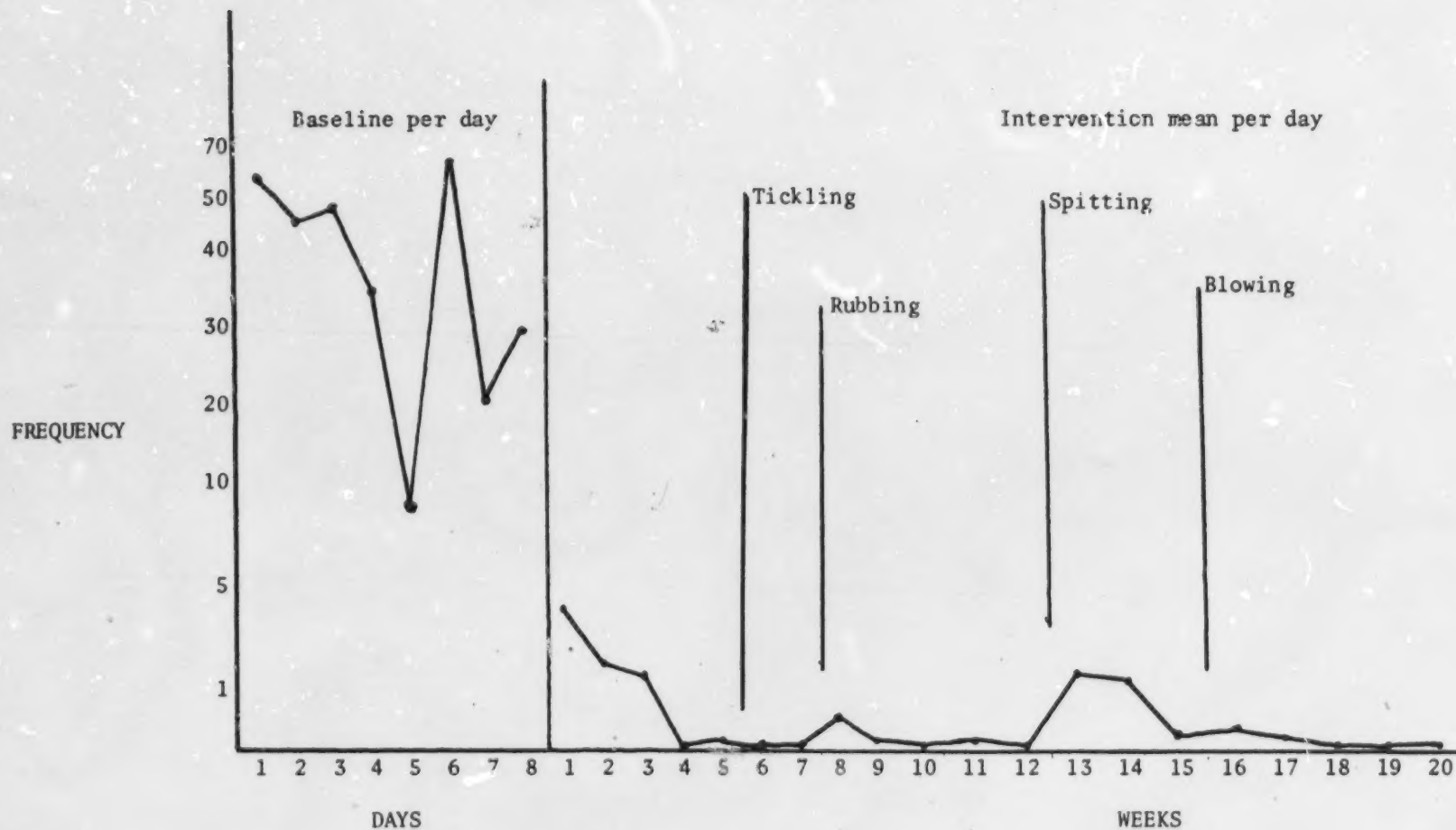
Baseline and Intervention Data for
Jim's Inappropriate Verbalizations



Thomas R. Brock

GRAPH II

Baseline and Intervention Data for
Jim's Aggressive Behaviors



FAILURE AS A STUDENT; SUCCESS AS A DROPOUT

Susan Hatfield
Area Education Agency 12
1520 Morningside Ave.
Sioux City, Iowa 51106

ABSTRACT: A multi-handicapped student experiences long-term school failure. After many interventions over an extended period of time, he eventually attains limited success outside the school setting.

March 1979

INTRODUCTION

The student, who shall be called Carl in this study, presented many problems which involved this examiner intermittently for over two and one-half years. Several agencies and professionals dealt with Carl and his family over this length of time by intervention and by attempting remediation.

Background information indicated poor school attendance, school problems, behavior problems of aggression, and a family life characterized by inconsistencies, instability and many changes of residence. It appeared that the family sought assistance only in crises, then subsequently dropped out as soon as there was any alleviation of the difficulty, or as soon as the intervention was perceived as unpleasant. The mother has been twice divorced and is currently on A.D.C.

Any changes in behavior on Carl's part have been hard to produce with so many compounding problems plus the lack of motivation for change. The prognosis has been and is guarded.

METHOD

When first seen by this examiner (8/76) Carl, age 12-10, and a patient of a local psychiatrist, was diagnosed as of average intelligence but having a learning disability. He disclosed fears of attending junior high school, of being committed to a mental health institute, and of being

sent to a residential treatment center. Carl also had an intense dislike for school as he perceived so little success. Poor family relationships among Carl, his three older sisters, and his mother contributed to the problems. It was learned at a later date that Carl had attended two different junior high schools during the seventh grade while exhibiting consistently poor attendance.

He next enrolled at a third junior high school (9/77) at which this examiner was the school psychologist. After attending school for one month, Carl refused to make up time for a teacher to whose class he had been tardy. He became verbally abusive and was sent to the office for disciplinary action. He again became verbally abusive, but more intensely, making several threats. The assistant principal ordered him suspended and to return with his mother. Within a half-hour, Carl and his mother returned bringing two neighbors for support. Carl screamed and yelled obscenities and threats, becoming generally uncontrollable. When it was learned that Carl had been seen by the psychiatrist only a month ago, it was suggested that perhaps the mother would wish to seek psychiatric help again. Certainly, Carl needed to be seen by the school support sources personnel for evaluation if he was to continue attending school there. Carl became more enraged over this turn of events and tried to rip up the referral form. The family left. Messages and inquiries sent to the mother were never answered. Apparently, the family had moved, and as it turned out, Carl was hospitalized in a mental ward for observation by his psychiatrist, who determined that Carl probably

would be classified as having a behavior disorder of adolescence with unsocialized aggressive reaction. Carl ran away to live in Texas with his older sister but evidently did not attend school there or anywhere the rest of the year.

Carl's next appearance (9/78) was at yet another junior high school, at which this examiner happened to be the school psychologist. Within a period of three weeks, Carl had 13 serious discipline referrals each involving three or more offenses, namely: swearing, drinking and smoking on school grounds, tardiness, refusing to obey teachers, threatening school personnel and students, fighting with other children, challenging teachers to fights, trespassing on school property, and carrying a knife. Meanwhile, the school social worker and psychologist became involved. Further testing by this examiner indicated an emotional disability with a chronically disruptive overlay and the still present learning disability. It was ascertained that Carl's reason for wanting to re-enter school was "to meet some chicks." By this time Carl had two suspensions from school, and the juvenile intake office was involved with the situation. Carl had managed to create a "macho" image for himself with a large following of girls and boys due to his good looks, "fearless ways", and a certain charisma. Furthermore, he started a gang called "The Panthers" and was the leader. Participation in the gang required carving tattoos on arms and inking them in.

A conference was scheduled to meet with Carl, his mother, and other interested participants. Since Carl's mother claimed she was sick, everyone trooped over to their apartment to hold the conference. Those persons attending were the Department of Social Services case worker, the school social worker, psychologist, the head counselor, the assistant principal, and a teacher who acted as advocate for Carl. From the ensuing discussion, it was discovered that, while on drugs during the previous year, Carl had beaten his mother severely enough to require hospitalization. At this time Carl, his mother, his 16 year old sister, her illegitimate baby, and her boyfriend lived in a small apartment which had just been condemned, necessitating another move for the family. It was determined then that Carl had a drug problem and that this should be attended to first. There was also talk of a possible ED placement or a residential placement. Carl was rebellious to all suggestions at first, but finally stated he did have problems and needed help. He agreed to go to the local chemical dependency unit for adolescents. Placement lasted one day for Carl who claimed it was "too weird" for him. A conference with the case worker from the unit was held. She felt Carl was too immature to benefit from their program, and probably did not have a serious drug problem.

A staffing was held with the school personnel, DSS case worker, and Carl, who was placed in the ED/SSC room. Certain stipulations on the IEP were set to assure a more successful intervention. Carl's goals were: to learn to control his bad temper, anger, impulsivity, and aggression;

to be where he should be - obeying school rules; to improve his math (one grade or more); to participate in a drug treatment program (since the other treatment failed, he joined a school drug therapy group); to work toward entering the 9th grade program through school performance and improved attitude; and to attempt to enroll in athletics (Carl was interested in football). A later goal was for Carl to assist in shop, and help the advocate teacher, previously mentioned, if he behaved in the ED class. Other recommendations by this psychologist included continued counseling, short work periods with earned free time, behavioral management techniques, a multi-modality teaching approach, a high rate of success in his work combined with positive reinforcement, and participation in the band (where he wanted to play the drums). Unfortunately, ingrained habits die hard. While Carl performed well in the small class setting for six days, being in the hall with other students was too much for him. He got into a very serious fight with another student, requiring five male teachers to pull them apart. He became insubordinate, making several threats, and was suspended. This psychologist documented this incident, and others resulting from it, recommending an immediate psychiatric evaluation with the possibility of residential treatment. Two more conferences attended by the DSS case worker, the social worker, and assistant principal were held; further treatment and psychiatric evaluation were also recommended.

Carl was seen by a psychiatrist and other case workers at the local mental health center. The upshot of the conference on this evaluation

was that there was really not much available in the way of help for children with needs like Carls. The mother finally decided to declare Carl a child in need of assistance, in order to receive financial help from the state. Two court hearings were held, and he was sent to the residential mental health center out of the city. Upon completion of their evaluation, the center recommended placement in a residential facility. The DSS case worker tried to find residential centers with educational programs that would enroll Carl. These attempts were unsuccessful as all seven contacted felt that Carl was too disruptive for their programs.

Meanwhile, Carl was released from the mental health center following his evaluation. He was sent to the community shelter care facility for two weeks and then placed back with his mother after spending some time with his uncle. There was talk in the family of Carl going to the West Coast to stay with another relative, but Carl found a job. His sister married and moved out. His mother attempted suicide, and Carl saved her; she is currently hospitalized. The case worker feels that the mother is so dependent on A.D.C. funds that she thinks she will no longer have any income with Carl working and his sister gone from the home. Evidently, she cannot cope with this possibility. Carl has returned to stay with his uncle.

A meeting was held at school (with the DSS case worker) to determine Carl's current educational status. The case worker reported that Carl's

work is important to him and that he no longer is interested in a school program, so he was checked out of the junior high school as of 3/20/79.

RESULTS

At the two evaluation sessions (9/78), this psychologist attempted to set up a line of thinking with Carl on relearning how to react to perceived provocations to his person or image. His usual modus operandi was to react with angry, hostile, aggression viewing this as the only method to deal with problems, disregarding entirely the consequences. These new ideas met with little success as Carl was so tuned into preserving a "macho" image, regardless of the consequences.

Further attempts at intervention had been made by this psychologist during the staffing of Carl into the ED room in the latter part of September, 1978. Carl was to talk to his teacher first if he felt upset before he did anything negative - physical or verbal. Then, if this did not work, his teacher would bring him to the head counselor, social worker, psychologist, or assistant principal for further counseling. Carl seemed to listen to this and agreed to try this strategy. It was not successful as he blew up in the hall six days later when his teacher was not available at that precise moment.

More counseling with Carl through the social worker, DSS case worker, and Carl's uncle was continued throughout the fall. The main thrust of this counseling was to re-educate Carl to behave in more socially acceptable

ways. Eventually, over the past seven months, the DSS case worker was able to establish an excellent working relationship with Carl, seeing him once a week or more, and discussing difficulties as they arose. Gradual improvement in Carl's behavior was indicated by his becoming more amenable to accepting treatment and evaluation, seeking out the case worker when he became upset, and becoming more responsible for his own behavior by not acting impulsively or aggressively, and by considering the consequences of his negative behavior. His case worker reports that Carl has been abiding by the curfew, obeying his mother, exhibiting a good attitude, and being responsible with his money.

DISCUSSION

Two main determiners appear pertinent in remediating Carl's behavior, which are his job and an on-going positive relationship with his case worker.

Carl's job provides him with some positive feelings of worth. He could only obtain these feelings previously through a "macho" street-image. Now he feels more confident and sure of himself. He enjoys earning money and finding something in which he is successful that is also socially acceptable. This improvement is observable, but the prognosis is still guarded as to whether Carl will be able to continue handling crises as they arise with appropriate, reasonable actions.

The positive relationships and trust established with Carl's case worker have assisted Carl in being able to learn to control his behavior in an acceptable manner. As Carl saw the positive reactions of others to his behavior, he gradually was more willing to try discussing his difficulties, and to solve his problems rather than resorting to physical or verbal aggression. Time and opportunity to work with Carl were necessary components of this successful intervention.

The fact that Carl required so much combined effort on the part of significant involved individuals and the school's inability to effect change due to the numerous negative influences, makes this examiner wonder how many other children like Carl need adequate programs and treatment facilities to meet the requirements of students exhibiting CD behaviors.

There is also the possibility that school programs are not going to be the answer for some children and that, as in Carl's case, they may make more progress outside the school setting.

GROUP COUNSELING
WITH STUDENTS IN A SECONDARY SCHOOL SPECIAL EDUCATION PROGRAM

Gerald Sallan

Heartland Area Education Agency
821 15th Street P.O. Box C
Boone, Iowa 50036

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ABSTRACT: A description of group counseling with students in a secondary school mental disabilities program is provided, as well as, a discussion of previous group counseling of students with mental retardation as described in the literature.

Though classes for students with low intellectual performance have been a part of the American public educational system for more than one hundred years (Anderson, 1958), little attention has been given to supportive guidance for developing adequate self-concept and assisting in resolving interpersonal conflicts.

Fine (1969) has stated:

The establishment of special classes for retarded children in Public schools seems to have ignored the implementation of certain necessary supportive services, such as counseling. Secondary and even elementary school guidance programs are geared primarily for the normal student and in many school systems the special teacher has questionably assumed the role of counselor (p. 105).

There are many reasons why the special education classroom teacher has assumed the role of "school guidance counsellor" for his/her students. First, supportive services (counsellors, school psychologists, school social workers, speech clinicians) were often very limited in manpower and the administrative staff felt that it was wiser for these professions to serve those students who were not already receiving some type of special service. The students in the special education program were already being given specialized treatment by the mere fact that their teacher had been specially trained to teach handicapped students, they were in smaller classes, etc.

Second, "traditionally, the mentally retarded have been regarded as poor candidates for counseling and psychotherapy primarily due to their level of intellectual functioning" (Friedland, 1974, p. 1). Once again in an effort to maximize the supportive service of these "extra" professionals, they were assigned to children who could make the most progress in the shortest amount of time, viz., students in the general education program.

Browning (1974) has commented that:

Most counselors and therapists believe that prognosis is poor for clients with low intellectual capacity. It seems almost inevitable that a

counselor would communicate pessimism to such patients as well as lower conditions, because he believed it could not help them. His lower level of therapeutic conditions, in turn, would lead to poor outcome and thereby confirm his original pessimism (p. 5).

However, Friedland (1974) felt that "this attitude is still prevalent in spite of the fact that persons with mental retardation can profit from many forms of psychotherapeutic intervention. "One of the most promising methods in working with this client population is group counseling" (p. 1).

Group counselling has been described as:

More than one individual in a structured but permissive situation in which directive discussion emphasizing the following areas:

- A. Home and family life as it affects school behavior
- B. Peer group relationships in and out of school
- C. Relationships with authority figures
- D. Attitudes toward academics
- E. Attitudes toward self
- F. Techniques of discussion, sharing, role playing (Mann, 1967, p. 10).

Gazda, Duncan, and Meadows (1967) have offered a more comprehensive definition of group counselling.

Group counseling is a dynamic interpersonal process focusing on conscious thought and behavior and involving the therapy functions of permissiveness, orientation to reality, catharsis, and mutual trust, caring, understanding, acceptance, and support. The therapy functions are created and nurtured in a small group through the sharing of personal concerns with one's peers and the counsellor(s)... The group counselee may utilize the group interaction to increase understanding and acceptance of values and goals to learn and/or unlearn certain attitudes and behavior (p. 305).

Some of the goals of group counselling with adolescents in a junior and/or senior high school program for students with mental disabilities might include: (1) to teach skills, (2) to accomplish a project, or (3) to develop or produce personal growth in the participants (Friedland, 1974).

Before a review of some of the previous group counselling with students with mental disabilities are described, a working definition of students with mental disabilities will be offered. For the purpose of this paper, individuals in a junior and/or senior high school program for students with mental disabilities

were defined as such: The student has achieved an I.Q. score on an individually administered intelligence scale (such as the Wechsler Intelligence Scale For Children or the Stanford-Binet) between 50 & 85 and academically are performing on a level between third and sixth grade in the areas of reading and written expression. As the reader can see, this definition encompasses those students who have been classified as educable mentally retarded and slow learning in the past or in other states than Iowa.

Mann (1967; Mann, Beaber, & Jacobson, 1969) using thirty-six males from the age of nine to thirteen years old in a public school program (E.M.R.) divided them into two groups matched on age, I.Q., race, social economic status. Each of the two main groups were subdivided into three subgroups. The experimental groups received group counseling over a twelve week period while the control groups were given supervised reading and library sessions.

The effects of group counseling on self concepts of young educable mentally handicapped boys were studied along with the variables of anxiety, deportment and achievement in reading and arithmetic as rated by teachers, attendance, I.Q. and age. Results indicated that those who received group counseling tended to exhibit greater improvement in self concept, more reduction in anxiety, and better grades in deportment and the academic subjects of reading and arithmetic, than those who did not receive the counseling. No significant difference was found between the experimental and control group in attendance. Age and I.Q. were not found to be significant factors in the counseled group (Mann et al, 1969, p. 359).

Self concept was defined in this study as:

An organized configuration of the perceptions of the self which are admissible to awareness. It is composed of such elements as the perception of one's characteristics and abilities; the precepts and concepts of the self in relation to others and the environment; the value qualities, and goals and ideas which are perceived and having positive or negative vlaues (Rogers, 1951, p. 501).

Fine (1969) attempted to provide group counseling to five educable mentally retarded boys between the ages of twelve and fourteen years old whom teachers had indicated were having behavioral problems. Fine used the client centered therapy approach in this study. After eight sessions, the group was

stopped from meeting by one of the school's principals due to "apparent lack of direction" and excessive noise. While Fine felt that some progress had been accomplished with this group, he commented that "individual counseling via client centered approach might hold more potential for this kind of child than a group experience" (Fine, 1969, p. 109).

However, Friedland (1974) found that there was a positive improvement on measures of self concept and personality testing for mentally retarded students receiving group counselling. He has explained that the goals of a group counselling experience could be (1) to teach skills, (2) to accomplish a project, or (3) to develop or produce personal growth in the participants.

DeBlassie and Cowan (1976) have pointed out:

There are two particular times in the lives of educable handicapped children when a greater need for the help of the counselor becomes evident. First, when they enter school they need help accepting and understanding their limitations without feeling sorry for themselves. Second, the handicap is brought to the children's attention even more forcefully during adolescence when they attempt to achieve independence and make the normal emotional adjustment that this time of change brings to any child (p. 247).

Responding to this apparent need on the part of students in a secondary school special education program (mental disabilities), the present author and a school social worker started holding weekly group supportive counselling meeting with the students in these programs during the later 2/3 of the 1977-78 school year. The remainder of this paper will describe in some detail the arrangement of the groups and the areas covered.

Two class periods a week (one at the junior high level and one at the senior high school level) were provided by one of the special education teachers for these meetings. The major impetus for starting these groups was best expressed by the teacher who stated, "These students have so many unexpressed needs and concerns. But since they're in special education, the counsellors

don't feel it's their job to talk with our kids; and I don't feel I have the training in this area to do the job properly." Secondly, while the school psychologist was meeting individually with particular students, the idea that it would be "neat" to deal with these concerns in a group setting was expressed.

At the initial meetings at the junior and senior high levels, one of the facilitators lead the discussion of the guiding principles the group was going to operate upon. These included: one person would talk at a time, all items discussed were confidential and would remain within the group setting, socially appropriate respect would be extended to all participants (students and adults), and every member of the group would have an opportunity to suggest an item or two for the group to discuss. It was especially emphasized that the participants had the right to discuss the items being discussed, pass (express the desire not to discuss it at this time), and to suggest additional items for discussion to be listed as part of the agenda.

At the start of each session, one of the facilitators would ask each participant to suggest an item which he/she would like to discuss in the group. Each suggested item was then listed on the chalkboard at the front of the room as part of the session's agenda. Some of the agenda items have included: marks for work done in the special education classes, attendance policy and make-up work, fighting, "Am I a big, middle, or small taker?" "Something I do well," field trips, how to respond to regular education students when they say you are a retard.

In an effort to assist the reader in better understanding how an item was dealt with in a group session, some of the above topics will be expanded. For example, part of a session was devoted to the discussion of "Something I Do Well." Each participant was asked to tell one of two things he/she felt he/she did well. Some of the items given by the participants were bowling, sewing,

cooking, reading, taking care of animals, fighting, and ice skating. As one of the girls was unable to think of anything she did well, the group was asked to help her out with suggestions of some of the things she did well. They suggested that she relates well with others. Many of the things the participants stated they did well were counter-checked by asking the group to express whether they had also observed that this particular individual did well at the particular items suggested. For the most part, the group seemed to agree with the individual's statement and in some cases, the group was surprised to find out that a particular individual enjoyed cooking or bowling for example. Towards the end of this discussion, a majority of the group expressed the fact that they very seldom think about the things they do well. Rather, they are often bombarded with their failures in reading, math, etc. They also expressed their appreciation for being allowed to explore the positive aspects they possess.

Another topic, which was raised, was concerning the make-up work required for an absence policy one of the special education teachers had established. The students felt that it was unfair to require them to make up the work missed during their absence. Many of them felt that the teacher was asking them to do more work than they would have done if they had been in class on the day they were absent. The students were also upset with the fact that zeros were entered into the grade book for each day the work was not handed in. After some of the students had had an opportunity to raise their concerns and questions regarding the policy, the facilitator asked the teacher to explain his rationale for the policy. The students listened and raised questions regarding the manner in which this make-up work procedure operated. What became evident, as the group was discussing this subject, was that only one or two students had been affected by having to make up work missed. Rather the students were concerned about what

would happen IF they were absent and had to do a make-up assignment. This general subject was resolved by the teacher indicating that he would consider modifying the procedure and wished to discuss this with a delegation of the students selected by them.

One session was devoted to a discussion of alternative ways of responding to others using the Transactional Analysis model of the three ego states. A lead statement such as "I got in a fight today" was presented and written on the chalkboard by one of the facilitators. Each participant was asked to offer a response statement to the lead sentence. The group offered such follow-up statements as "That's too bad", "Who won?", "You shouldn't fight!", "Did you get hurt?" and "What was the fight about?". Following this, the group was asked to identify whether the follow-up response was a member of the child, parent, or adult ego state. It was discovered that a statement could fall within one or two ego states depending upon how it was said and the response that followed it. After the follow-up sentences were placed in an ego state category, the lead sentence and each follow-up response were paired with a probable response of the person who offered the lead sentence, e.g., Person A: "I got in a fight today" Person B: "You shouldn't fight!" Person A: "I had to and anyway he started it first". As one of the participants pointed out, we have many different ways we can respond to a person and it sometimes depends upon who the other person is and how we feel at that particular time.

The last group experience that will be described in this paper, is the use of video tape unit within the group counselling setting. Part of a session was video taped while the group was discussing the qualities they desired in a boyfriend or girlfriend. After the group had discussed this topic for about fifteen minutes, the video tape was stopped and played back for the group to view. Midway through the playback, the tape was stopped and the group discussed

what they observed happening. Some of the students mentioned that a student was blushing or laughing whenever something of an "intimate, caring" nature was mentioned. One of the participants' actions was discussed at some length as this young lady was saying one thing, but her body language was indicating just the opposite. Some of the students mentioned that they were not aware that they were talking to their neighbor when another student was leading the discussion. In general the participants expressed the feeling that they learned more about how they act and respond in a group discussion. They also stated that they enjoyed seeing and hearing themselves as others see them and expressed the desire to use the video tape unit again.

With the advent of Public Law 94-142: The Education for Handicapped Children Act of 1975, recent court decisions that local school districts must provide appropriate educational programs for all students (Wald, 1977) and the implementation of mainstreaming, it is imperative that students be provided with an opportunity to receive supportive counselling service whether they are in general or special education programs, as well as, learning to read and do mathematics. This need for supportive guidance becomes increasingly more important as students with an educational disability enters a secondary school special education program. Friedland (1974) in discussing the work of Halpern and Bernardhas indicated that "impairment in adaptive behavior is generally considered to be the primary deficit of the mentally retarded" (p. 2). He also has suggested that "the group approach itself is the most appropriate for enhancing the client's social adaption since the group itself is a social milieu. In addition, it provides a medium for making choices which approximates those made in the outside world" (p. 2).

Since most counsellors at the junior and senior high school level have traditionally had very little training and formal interaction with students in a

secondary school special education program, it would seem that supportive service personnel, such as the school psychologist and school social worker, could provide a valuable service to both the special education students and the counselling staff at the local school by conducting demonstration group counselling sessions and observing those sessions led by one of the school's guidance counsellors.

It is anticipated that the two groups described earlier in this paper will be continued during the next school year and that one of the school's guidance counsellors will become the primary facilitator of the groups with the school psychologist acting as a support agent to the counsellor.

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MOBILITY, REDIRECTIVE AND PRAISE
CRITICISM RATIO INCREASES OF STUDENT TEACHERS
AS A RESULT OF CONTINGENT POSITIVE PRACTICE

William R. Wright
1932 S.W. Third
Ankeny, Iowa 50021

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Teacher attention has been demonstrated to be a powerful agent for producing change in students behavior in many educational settings (Hall, Lund and Jackson, 1968; Hart, Reynolds, Baer, Brawley and Harris, 1968; Schutte and Hopkins, 1975; Madsen, Becker and Thomas, 1968; Hall, Fox, Willard, Goldsmith, Emmerson, Owen, Davis and Porter, 1971; Sajwaj, Twardosz and Burke, 1972; Pinkston, Reese, LeBlanc and Baer, 1973). While leaders in the application of behavioral principles point out the need for educational staff to be trained to provide frequent attention and ignore inappropriate behaviors of clients (May, Riley, Twardosz, Friedman, Bijob, Wexler, et al, 1976) there is some question as to what training component is most desirable. Hall, Panyan, Robon and Broden (1968) depended upon special training, feedback and social reinforcement to train teachers. Walker and Buckley (1972) used programmed texts to achieve their ends. Feedback (Cooper, Thomson and Baer, 1970) social praise (Cossairt, Hall and Hopkins, 1973) modeling (Ringer, 1973) and auditory cueing via a public address system (Houten and Sullivan, 1975) were other strategies used to increase teacher praise rates.

The dilemma exists in that while it is generally agreed that "... the higher the positive teacher ratio (praise-criticism) the greater is the students responsiveness to the learning situation (Madsen and Madsen, 1970)", a quick and easy method to prompt such ratios still eludes educators. As Rosenfield (1979) points out, even at a university setting "... instruction alone without guided practice. . . (p 335)" may not be sufficient to help teachers form such praise criterion ratios.

It follows then that a method of prompting is needed which would increase praise rates, decrease criticism rates and increase a teachers ability to ignore previously attended to inappropriate behaviors. One powerful method of prompting which increases desirable behaviors while concurrently decreases inappropriate behaviors is Positive Practice (Foxy and Azrin, 1973). Conceptually it is a procedure which terminates reinforcement of the on-going inappropriate response, provides

negative reinforcement for the practice of desired behaviors, constitutes a time-out in that the ongoing inappropriate response chain was interrupted and provides a re-education component of the appropriate response in the form of positive practice (Azrin and Wesolowski, 1974).

METHOD

Subject and Setting

Students at an area community college enrolled in both child care and developmental disabilities were selected for the study. During baseline and treatment course work and laboratory experience was identical for both groups. Child care student underwent experimental conditions while developmental disability students served as a control. During the laboratory experience at least four students would interact with day care children ranging in age from approximately three to six years. The maximum numbers of children never exceeded 37.

Observational Procedures

Observers recorded baseline and treatment conditions on a coded tally sheet. With a video tape back-up for reliability, observations were made by a mark under the appropriate column denoting the type of interaction for each child. Categories were coded and in addition observers randomly delayed recording after an interaction occurred for the purpose of exhibiting the temporal pairing of the recorded response and the emitted behaviors by the student-teacher.

Response Measures

Teacher behavior was measured on three broad categories of positive, negative

and natural interactions. Positive and negative interactions were further broken down into general and specific categories.

Any vocal emission directed to a child for the purpose of showing approval which was response specific was recorded as specific praise. Examples are "good walking", "I like the way you are sharing your toys" etc. Praise statements such as "Your doing a good job" or "Good" were recorded in the general category.

Any vocal emission directed toward a child for the purpose of stopping an ongoing response was recorded in the specific criticism category. Remarks such as "Stop fighting" or "Get off the table" are examples. Vocal emissions which were intended to reduce the child's behavior and did not draw attention to the ongoing inappropriate behavior was recorded in the redirection category. All other teacher vocal behaviors such as reading books or giving directions was recorded in the neutral category.

An interaction; positive specific; positive general; negative specific; redirective or neutral was recorded as having occurred when the vocal emission was heard by the observer. The occurrence was defined as terminated when the student teacher being observed left the child, attended to another person in the room, or changed a response category.

Reliability

Reliability was taken by an additional observer in the room at various times during the study in addition to comparing data sheets to video tapes. Questionable data was recorded only if it was substantiated by video tape comparisons. This forced the reliability measures to approximately 100%.

Treatment

"Baseline" (A) Student teachers were told they were being investigated as to their interactions with children. No other specifics were mentioned. Baseline

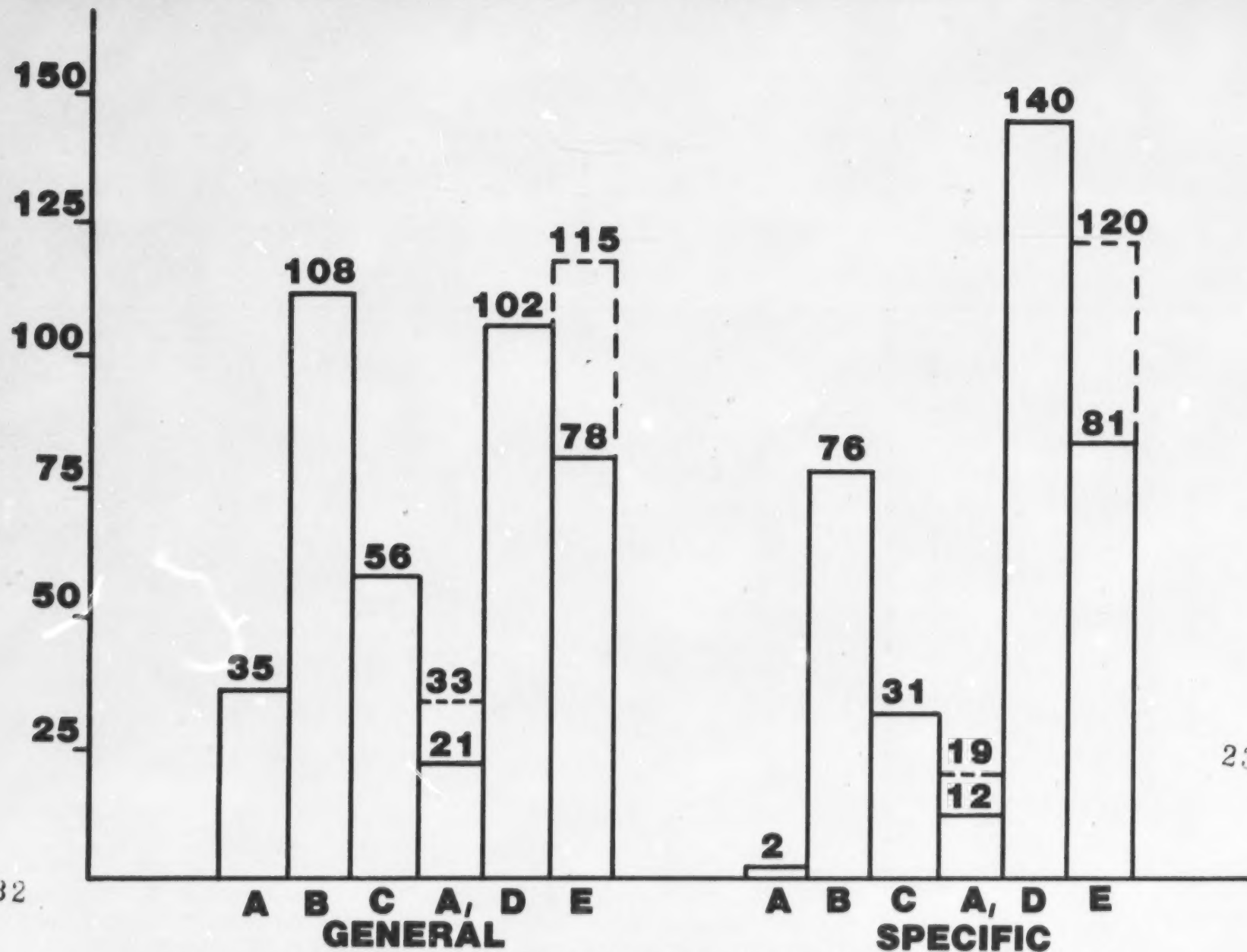


FIG. 1 ACTUAL AND PRORATED TOTAL TEACHER PRAISE EMISSIONS PER CONDITION

consisted of collecting data on 30 students for 10 minutes each.

"Treatment" (B) Whenever a student teacher did not engage in any type of interaction or continued to engage in any type of interaction for a period of more than 20 seconds, she was cued by the observer. Upon receiving a cue the student teacher was required to stop what she was doing and praise four children in a response specific fashion.

Treatment 2(C) Whenever a student teacher was engaging in a negative specific interaction, she was cued and required to stop what she was doing and praise four children in a response specific fashion.

Baseline 2(A₁) Data collection only

Treatment 3(D) Cueing was discontinued and students received feedback as to praise and negative interaction rates immediately after each observation by the observer handing the student a summary tally sheet.

Treatment 4(E) In addition to the summary tally sheet, a group chart was displayed in the classroom depicting praise and negative interaction rates. All experimental conditions consisted of 30 observations.

RESULTS

All displayed data does not include any praise emission that was the result of receiving a cue. Figure 1 displays general and specific praise emissions per condition for the study. For comparative purposes, any condition which consisted of less than 30 observations was prorated to be proportionally equal.

Insert figure one about here

Figure 2 displays negative and redirective emission across conditions while figure 3 compares the summation of general and specific praise rates to the summation of negative and redirective praise rates.

Insert figure 2 and 3 about here

A praise-criticism ratio was computed by adding the general and specific praise emissions and dividing by the negative emission. The praise criticism ratio per condition is displayed in figure 4.

Insert figure 4 about here

Additional data displayed in figure 5 depicts the total neutral vocal interaction emitted by the student teacher for each condition.

Insert figure 5 about here

At various times during the study students in a control group were selected randomly for data collection. Control data was prorated to a proportional amount for 30 observations and is displayed in figures 6, 7, and 8.

Insert figure 6, 7, and 8 about here

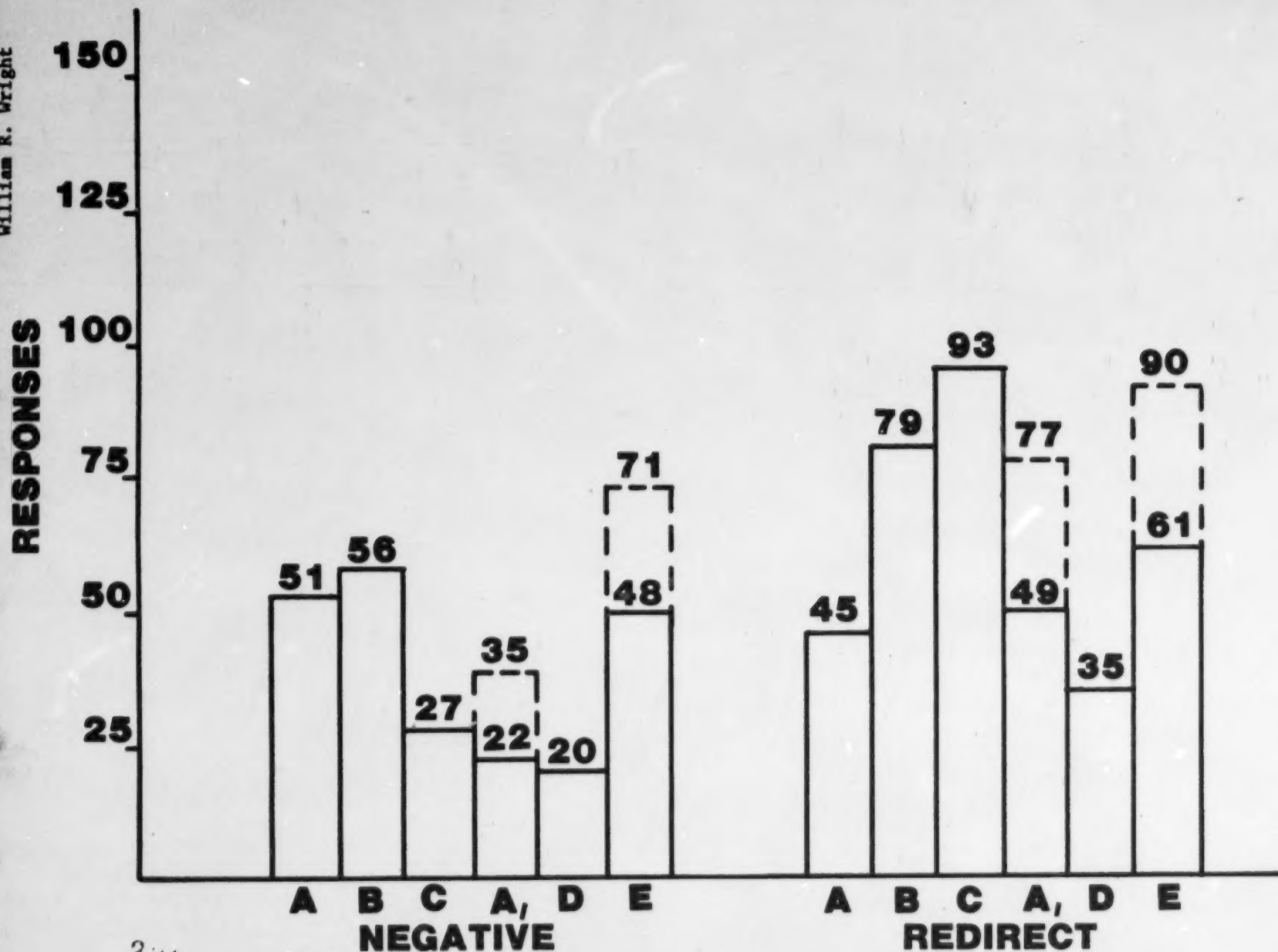


FIG. 2 ACTUAL AND PRORATED TEACHER NEGATIVE AND REDIRECTIVE EMISSIONS PER CONDITION

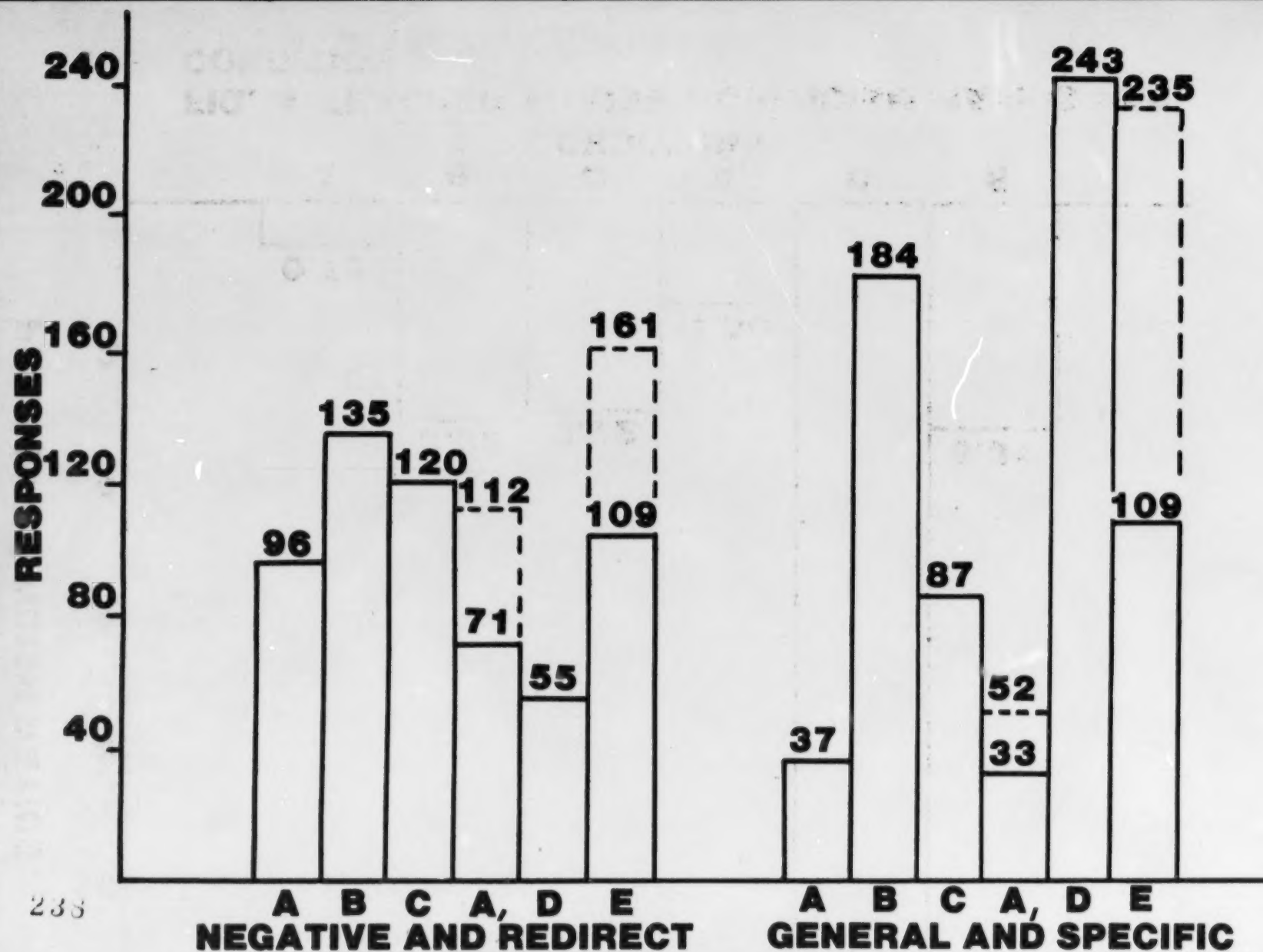


**FIG. 3 ACTUAL AND PRORATED TEACHER PRAISE
REDIRECTIVE AND NEGATIVE EMISSIONS PER CONDITION**

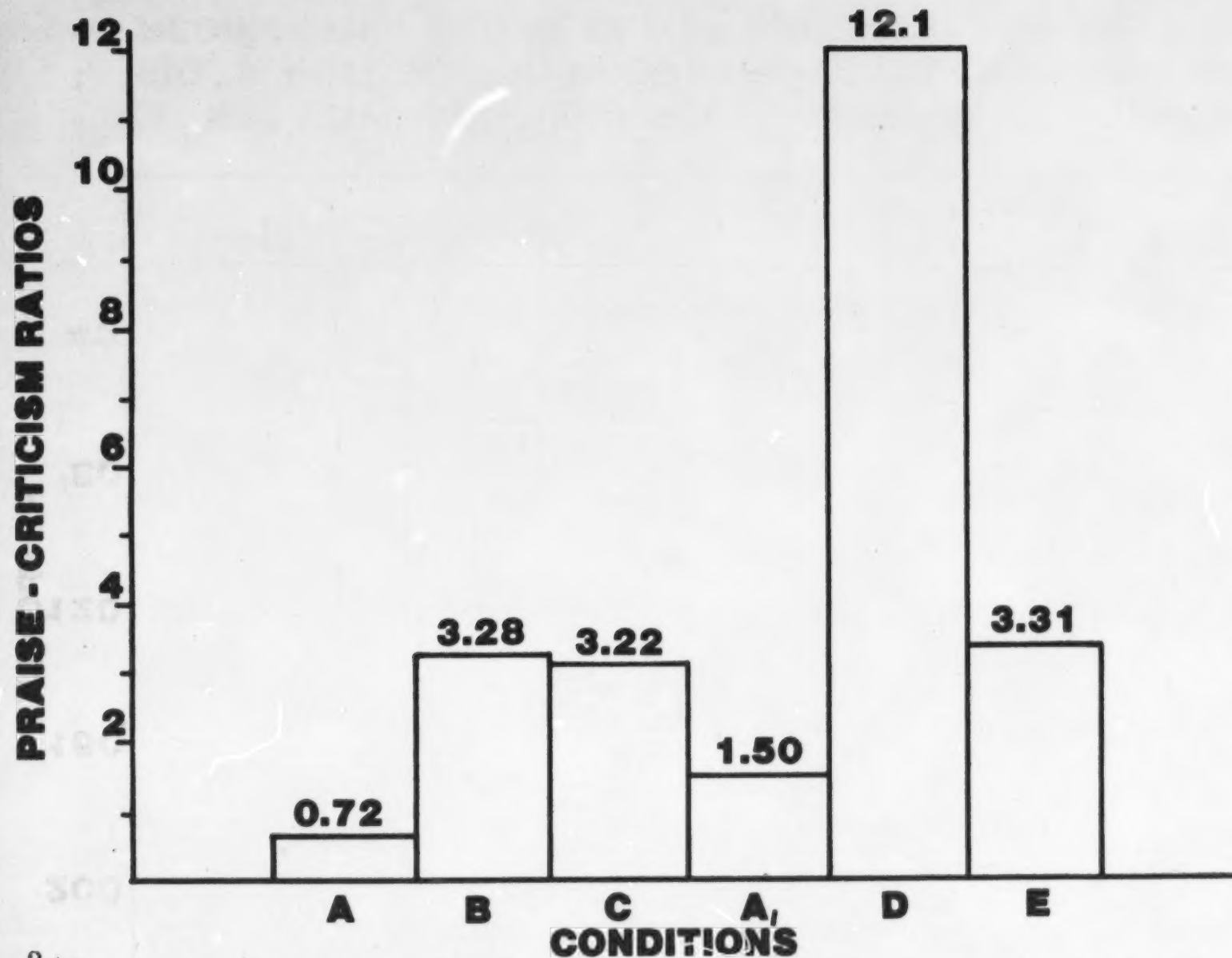


FIG. 4 TEACHER PRAISE - CRITICISM RATIOS PER CONDITION

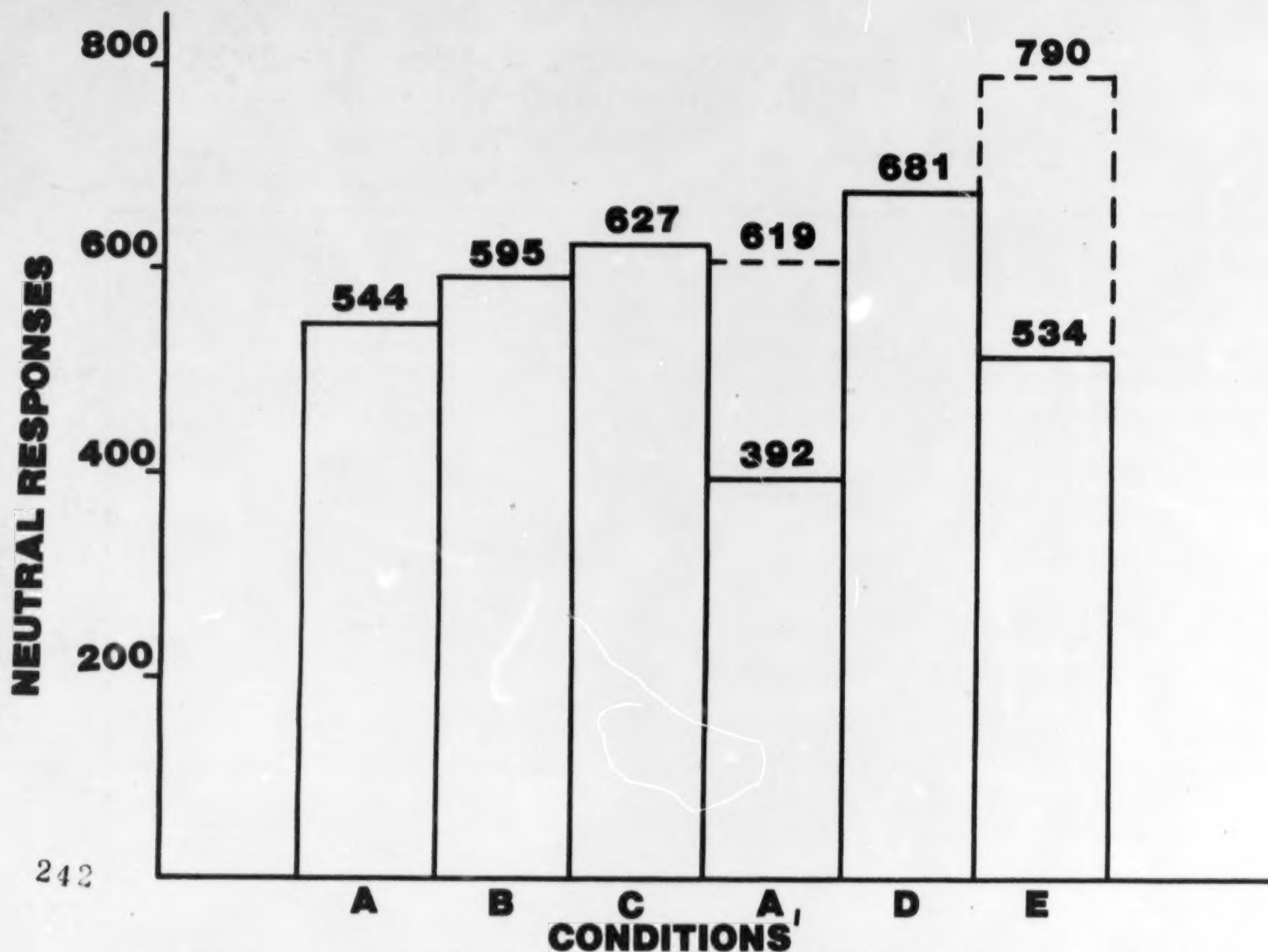


FIG. 5 TOTAL GROUP NEUTRAL TEACHER EMISSIONS PER CONDITION

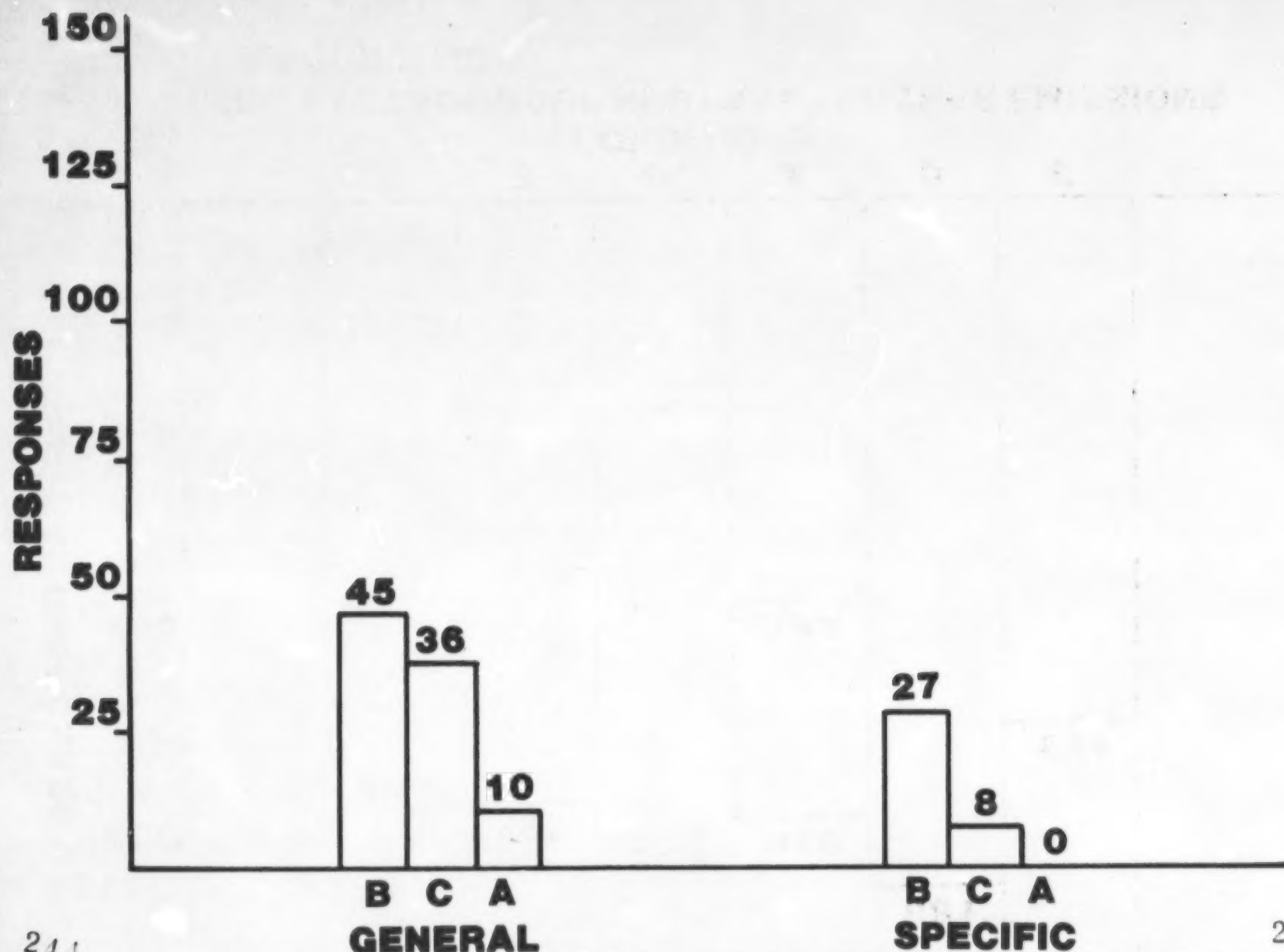


FIG. 6 CONTROL GROUP PRORATED SPECIFIC AND GENERAL PRAISE EMISSIONS

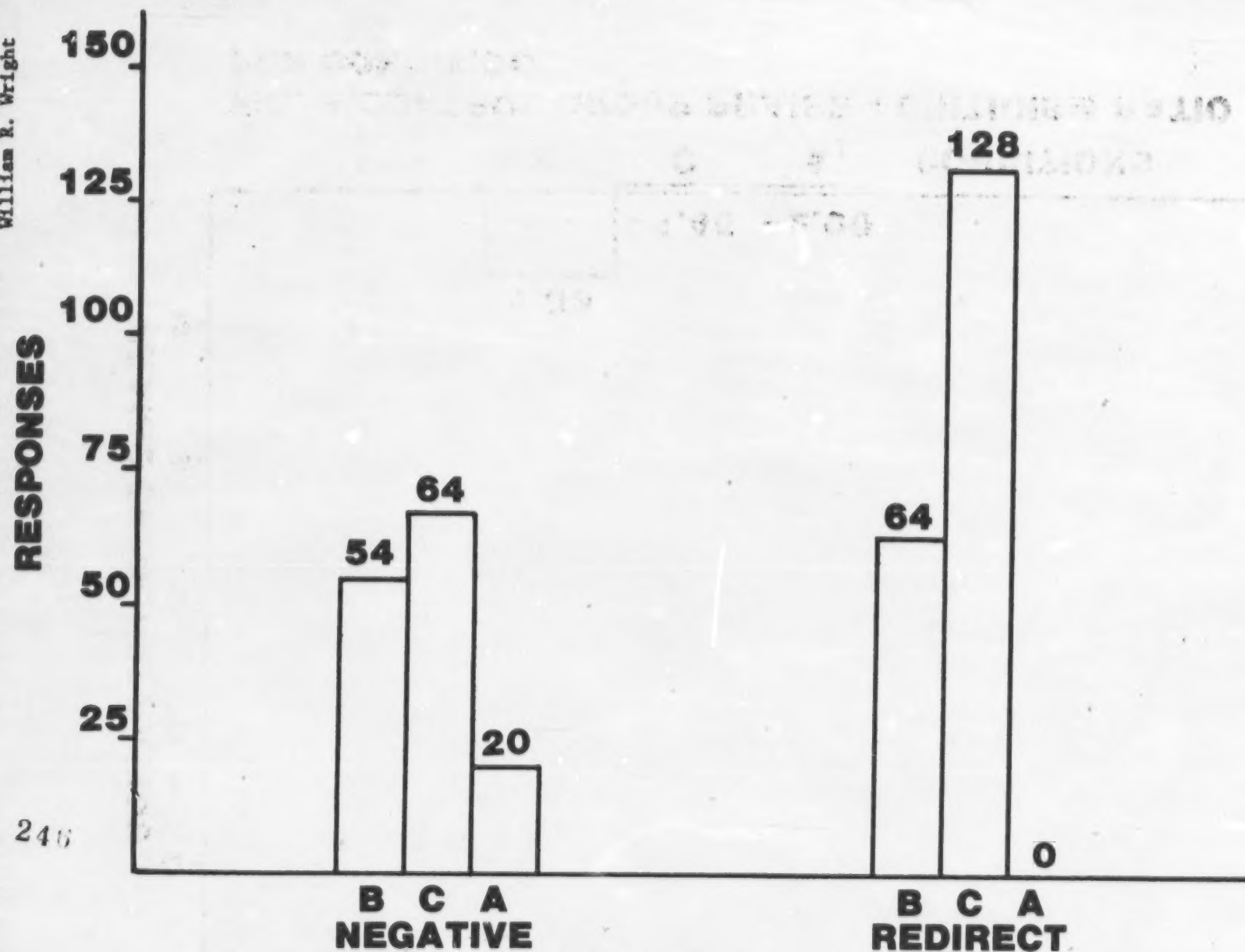


FIG. 7 CONTROL GROUP PRORATED NEGATIVE AND REDIRECTIVE EMISSIONS PER CONDITION

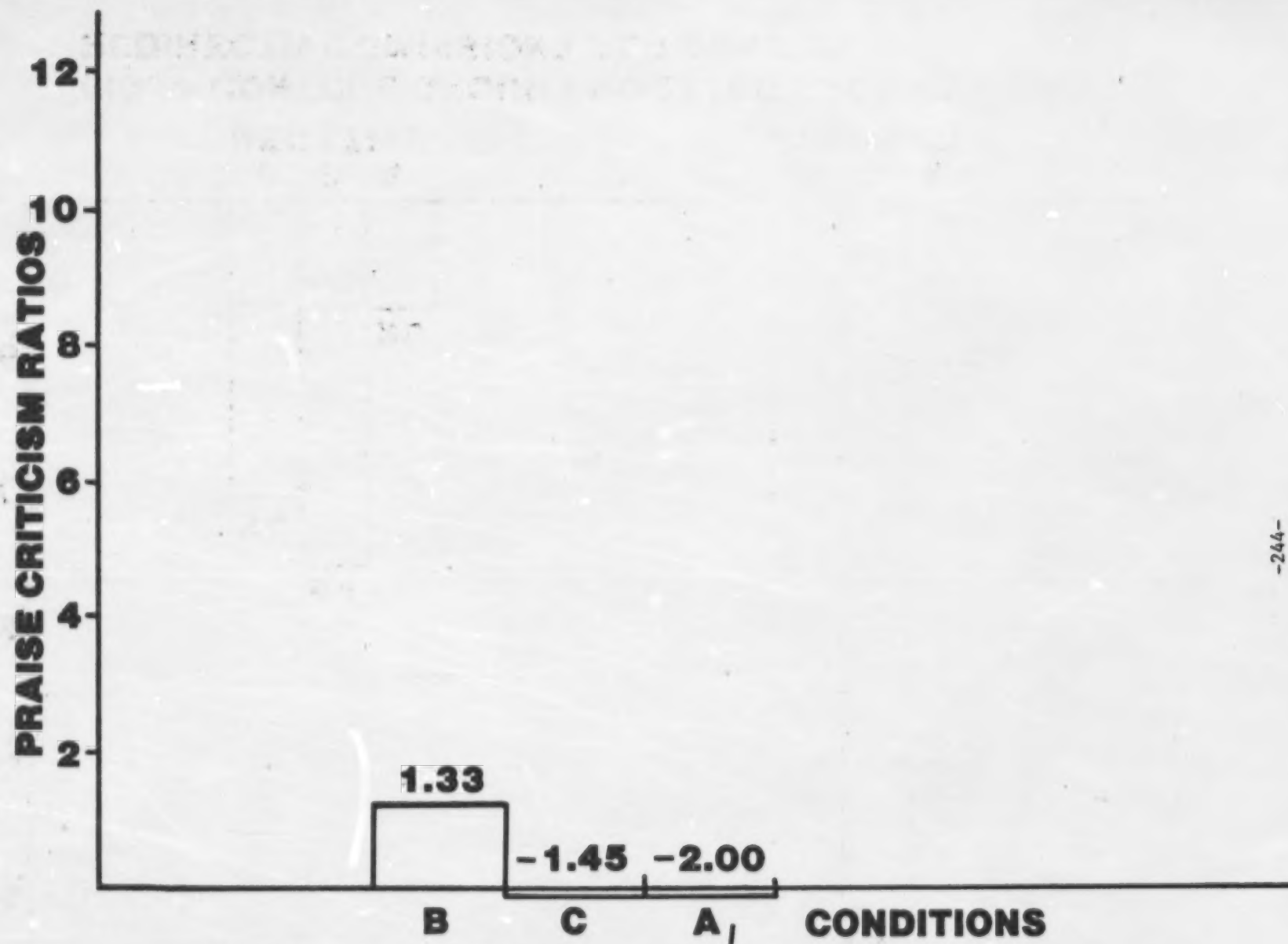


FIG. 8 CONTROL GROUP PRAISE - CRITICISM RATIO PER CONDITION

DISCUSSION

The effect of applying a positive practice procedure to student teachers resulted in (1) an increase in mobility when acquiring four praise emissions contingent upon a 20 second lack of interaction; (2) an increase in praise emissions and decrease in negative interactions when contingent upon negative interactions; (3) an increase in redirective responses; and (4) an increase in overall praise-criticism ratios. Control student data clearly points out that this was a treatment effect alone.

During baseline student teachers were more negative than positive. In addition the inappropriate attending to child misbehavior was at fairly high levels. While data was not collected on the actual number of times child behavior was appropriately ignored, it is suggested that this happened frequently during and after condition C.

Due to the suppression effects of a positive practice procedure it is important to note data displayed in figure 5. Neutral emissions are steadily increasing across conditions so one may conclude that verbal behavior as a whole response class was not suppressed, only a specific subset.

The effect of individual and group feedback resulted in a curious data display. Individual feedback dramatically increased the praise rates. A substantial decrease in the praise criterion ratio is noted as a result of group feedback via public charting. This was not a result of a decrease in praise emissions but rather an increase in negative and redirective emissions. One may only speculate if this were not just the "misery loves company" effect or the dissipation of the suppression effects positive practice. However, it should be pointed out that the type of feedback may be an important variable for further investigation not merely feedback as a condition in and of itself.

SUMMARY

Positive practice for teachers appears to be a viable training technique for prompting a discrimination. Lack of mobility and negative interactions can be suppressed while praise, mobility and redirective behaviors can be increased. Feedback can be of additional value but one should be cautious as to the type used. Data also supports positive practice as a punishment technique.

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